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Community Reentry, Mental-Health and Substance Abuse Treatment, and Stigmatization: A Qualitative Study of Ex-Offenders

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Philadelphia College of Osteopathic Medicine

Department of Psychology

COMMUNITY REENTRY, MENTAL-HEALTH AND SUBSTANCE ABUSE
TREATMENT, AND STIGMATIZATION: A QUALITATIVE STUDY OF EX-
OFFENDERS

Deborah Luckey

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

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DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by Deborah Luckey
on the 13th day of May, 2016, in partial fulfillment of the
requirements for the degree of Doctor of Psychology, has been examined and is
acceptable in both scholarship and literary quality.

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Abstract

This qualitative study was conducted with ex-offenders who are currently in reentry programs and professionals who have contact with them in order to explore experiences of stigmatization, as well as access and adherence to mental-health and substance abuse treatment. A better understanding of what works and does not work, from the viewpoint of individuals actively engaged in the process of reentry, is needed in order to assist them with successful reentry. A total of 11 participants were in the study; six were in the ex-offender group and five were in the professionals group. All individuals were interviewed using a semistructured interview and completed demographic forms. The interviews were coded for emerging themes using grounded-theory research design. The themes found included (a) the barriers ex-offenders faced post release to access and adherence to mental-health and/or substance abuse treatment; (b) positive experiences with mental-health and/or substance abuse treatment while incarcerated on accessing and adhering to treatment post release; (c) impact of having a positive support system, including family, friends, and professionals, during the reentry process on recidivism and treatment adherence; and (d) the impact that stigmatization has on the treatment decision-making process.

Keywords: ex-offenders, reentry programs, mental-health treatment, substance abuse treatment, stigmatization, adherence to treatment, treatment decision-making, treatment barriers, service engagement

Table of Contents

Chapter 1: Introduction	1
Statement of the Problem	1
Literature Review	3
Prevalence of Mental-Health and/or Substance Abuse Problems in the Offender Population	3
Treatment in Corrections	8
Recidivism	11
Reentry Programs	12
Initiatives implemented for re-entry programs	13
Factors of re-entry programs	15
Fundamental components of successful re-entry programs	16
Challenges to achieving successful re-entry	21
Perspectives on Community Reentry from Offenders and Ex-Offenders	23
Outcomes and Effects of Community Reentry	27
Stigmatization	29
Purpose of the study	36
Research questions	36
Chapter 2: Method	38
Overview	38
Research Design and Design Justification	38
Participants	42
Inclusion and Exclusion Criteria	43
Recruitment	43
Measures	44
Procedure	45
Biases	46
Chapter 3: Results	49
Emerging Themes	49
Research Questions' Findings	55
Chapter 4: Discussion	57
Suggestions for future work	60
Limitations of the current study	62
References	64
Appendix A-Demographics questionnaire for ex-offenders	76
Appendix B-Interview questions for ex-offenders	78
Appendix C-Demographics questionnaire for professionals	79
Appendix D-Interview questions for those who have professional contact with ex- offenders	80

Table

Table. Ex-Offenders' Demographic Information43

Chapter 1: Introduction

Statement of the Problem

As of the year 2000, approximately 1,400 adult correctional facilities were providing mental-health treatment to inmates (Beck & Maruschak, 2001). Within these facilities, approximately 151,000 inmates were involved in mental-health therapy or counseling programs, about 115,000 inmates were receiving psychotropic medications, and 19,000 were being held in 24-hour-care units (Beck & Maruschak, 2001). These numbers demonstrate that U.S. prisons and jails have become the largest mental-health treatment providers (Adams & Ferrandino, 2008; Torrey et al., 2014). Additionally, approximately 70 to 80% of individuals who are currently incarcerated are dually diagnosed with both substance misuse and mental-health problems (Hartwell, 2004).

Reentry into the community is especially challenging for these individuals (Van Olphen, Freudenberg, Forten, & Galea, 2006). When inmates are released from prison, a majority engage in mandatory reintegration planning in order to decrease the possibility of recidivism and make for a smoother transition into community living (Draine, Wolff, Jacoby, Hartwell, & Duclos, 2005). Individuals with mental-health and substance abuse problems have higher rates of recidivism compared to other inmates, and they have been reported to experience distress and interference with their social and emotional adjustment as a result of their mental-health problems (Lurigio, Rollins, & Fallon, 2004). These adjustment and reintegration problems are evidenced in such domains as housing, employment, substance abuse rehabilitation, and medical- and/or mental-health treatment (Malik-Kane & Visher, 2008; Wilson & Draine, 2006).

On average, 64% of released offenders who are mentally ill are rearrested within 18 months of release (Lovell, Gagliardi, & Peterson, 2002). Additionally, during the first year of their release, only 50% of offenders with mental illness received mental-health services (Lovell et al., 2002). Overall, the level of community services ex-offenders with dual diagnoses receive following release is not sufficient (Lovell et al., 2002).

In addition to the lack of services available to this population, different types of stigmatization can have an effect on treatment quality, adherence, and successful reentry. One type of stigmatization that affects treatment quality for this population is public stigma (Corrigan & Watson, 2002). Public stigma is the attitudes and beliefs that individuals in the community may have towards people who have mental-health and/or substance abuse issues and have been recently released from prison (Livingston, Rossiter, & Verdun-Jones, 2011; Van Olphen, Eliason, Freudenberg, & Barnes, 2009). Public stigma has been identified as a substantial barrier to successful community reintegration (Lebel, 2011; Livingston et al., 2011; Van Olphen et al., 2009). Individuals who experience stigmatization may also internalize these beliefs and develop self-stigma or negative internal labels (Livingston et al., 2011). One outcome of self-stigmatizing beliefs is poor adherence to treatment, as individuals believe stereotypes that these conditions are chronic and cannot be helped, which can result in a loss of hope and motivation (Corrigan & Watson, 2002; Van Olphen et al., 2009). Both stigmatization by others and self-stigmatization have a substantial impact on the reentry process and adherence to mental-health and substance abuse treatment.

Past research has described the many barriers that this population faces upon release and the resources available to assist them with overcoming these barriers. However, even with these resources in place, such as reentry programs, individuals often either do not adhere to or obtain proper treatment for their mental-health and/or substance abuse problems and continue to have high recidivism rates (Mellow & Christian, 2008; Pogorzelski, Wolff, Pan, & Blitz, 2005). Limited qualitative research has examined the link between mental-health and substance abuse treatment adherence and the role that perceived stigmatization and self-stigmatization may play in the reentry processes for ex-offenders currently enrolled in reentry programs. The majority of studies completed are primarily survey based and quantitative in nature. These studies focus primarily on the general-offender population, instead of on those with mental illnesses and/or substance abuse issues. These studies also focus on general barriers to successful reentry, including housing and employment, as opposed to mental-health and substance abuse treatment factors. More information is needed about the process of reentry that those with mental illness and/or a dual diagnosis of mental-health problems and substance misuse issues go through upon release from prison and about the journey they take to obtain proper treatment.

Literature Review

Prevalence of Mental-Health and/or Substance Abuse Problems in the Offender

Population Mental-health problems are more prevalent among prison populations compared to the general public (Blitz, Wolff, Pan, & Pogorzelski, 2005). Mental-health problems are commonly defined by the presence of two components: a recent history of mental-health issues or symptoms related to a mental-health diagnosis (James & Glaze,

2006). The individual's mental-health problems must have resulted in a clinical diagnosis and/or treatment by a mental-health professional. The second component, symptoms related to a mental-health diagnosis, should be based on criteria specified in a manual, such as *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013; James & Glaze, 2006).

More and more individuals with serious mental illnesses find themselves in the criminal-justice system instead of the mental-health system. According to the Bureau of Justice Statistics (BJS; 2014), jails consist of locally operated facilities designed for short-term sentences. Inmates held in jails are usually awaiting trial and/or sentencing or are sentenced to a term of equal to or less than 1 year. Jail inmates are therefore usually convicted of misdemeanors or less serious crimes. Examples of these types of crimes would be loitering, public drunkenness, and petty theft (BJS, 2014). Prisons are longer term facilities run by the state government. Prison inmates usually have felony charges or sentences longer than 1 year (BJS, 2014). In addition to these two types of correctional facilities, federal prisons house inmates charged with federal crimes and forensic hospitals house inmates with serious mental illnesses who are incapable of residing in a general correctional facility or who have been adjudicated not guilty by reason of insanity (BJS, 2014).

The high number of individuals with mental illnesses in correctional facilities can be attributed to a number of factors, particularly the high number of discharges from state hospitals, restricted commitment laws, and less effective treatment systems (Fisher, Silver, & Wolff, 2006; Lurigio et al., 2004). The research literature points to deinstitutionalization as one of the major contributors to the shift of care from mental-

health centers to criminal-justice systems. Post World War II, mental hospitals released many patients to community facilities for follow-up treatment and services. The number of hospital beds was eventually reduced from a high of 559,000 in 1955 to 72,000 in 1994 (Center for Mental Health Services, 1994; Fisher et al., 2006). The decreased number of beds led to an increase in medication use as a form of treatment, increased but ultimately inadequate funding for community mental-health centers, and more insurance coverage for treatment of mental illnesses in general hospitals as compared to state hospitals (Fisher et al., 2006; Lurigio et al., 2004).

Another contributor to this shift in care was the revision of statutes governing involuntary psychiatric commitment, narrowing the grounds for commitment. In order for an individual to be involuntarily committed, the person needed to be deemed “a danger to themselves or others” and/or to have “a grave disability” (Fisher et al., 2006). The changes to commitment criteria made involuntary commitment more stringent and release from hospitals less stringent. These reforms resulted in a greater number of individuals with mental illnesses in the community who were vulnerable to engagement with the criminal-justice system (Fisher et al., 2006; Lamb & Weinberger, 1998). The trend of placing individuals with mental illness in the criminal-justice system for behaviors that are linked to their mental-health illnesses should be considered a form of criminalization (Abramson, 1972; Lamb & Weinberger, 1998; Teplin, 1984; Torrey et al., 1998). Criminalization refers to a process whereby behaviors that were once dealt with by sending the individual to mental hospitals for treatment are now being dealt with by the criminal-justice system, especially misdemeanors, such as loitering, trespassing, and other nonviolent offenses. The involvement of the criminal-justice system is thought

to be largely a result of the lack of appropriate treatment available for this population and restrictions placed on civil commitment policies (Fisher et al., 2006). Additionally, social problems, including homelessness, poverty, and unemployment, play a significant role in the criminalization process of individuals with mental illnesses (Draine, Salzer, Culhane, & Hadley, 2002).

Treatment is often fragmented for individuals with dual diagnoses and does not meet their more complex service needs (Lagerge & Morin, 1995). Often the services are provided for specific groups of patients, separating individuals with mental illnesses exclusively from those with only substance abuse issues. Each of these programs has its own eligibility admission criteria that need to be met before placement in the programs. One common eligibility requirement for participants in mental-health programs is abstinence from substances. This requirement causes a conflict if the person is currently dealing with substance abuse issues. Owing to these stringent admission criteria implemented in these treatment programs, many individuals who have co-occurring disorders are deprived of much needed services (Abram & Teplin, 1991). Without access to appropriate services, these individuals have a higher likelihood of coming into contact with police officers, who are likely to arrest them and place them into the criminal-justice system (Brown, Ridgely, Pepper, Levine, & Rylewicz, 1989). The mental-health field is aware of this problem, and in response, many service systems are attempting to shift toward implementing dual-diagnosis services based on the available research and integrating it into practice over time (Drake et al., 2001). Integrated treatment also has been shown to have better outcomes, including

reduced arrest rates, when compared with mental-health and substance use treatments that occur in parallel (Mangrum, Spence, & Lopez, 2006).

The war on drugs that started in 1971 further added to the growing number of offenders with mental illness in the criminal-justice system (Lurigio et al., 2004). During this period, many individuals were arrested and convicted for the use, sale, and possession of drugs. This group was considered the fastest growing subpopulation in the prison system (Beck, 2001). A large number of these individuals had co-occurring mental illnesses and substance abuse issues, which caused them to get caught up in the criminal-justice system (James & Glaze, 2006; Malik-Kane & Visser, 2008). Lurigio et al. (2004) noted that changes in policing tactics that resulted in zero tolerance for a number of public offenses are also likely to have contributed to this increased incarceration of individuals with mental illnesses. Many of these offenses are common behaviors among mentally-ill offenders, including loitering, aggressive behaviors, trespassing, disturbing the peace, and urinating in public (Lurigio et al., 2004). Both of these events added to the growing number of inmates with mental-health issues.

In summary, individuals with mental illnesses and/or substance abuse issues are more likely to find themselves involved with the criminal-justice system. The effects of the main factors for this increase, including deinstitutionalization and political reforms, have evolved over the years, and the effects of these policy changes continue to affect arrest rates to date. Owing to the growth of this population in prisons and jails, additional resources continue to be needed to address mental-health and substance misuse issues during the person's incarceration. One of these accommodations should be appropriate treatment options.

While incarcerated, inmates who are diagnosed with mental illnesses and/or substance abuse disorders have human rights and are entitled to appropriate treatment. The Standard Minimum Rules (SMR) for the Treatment of Prisoners (SMR, 1957, 1977) states, “The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end”. Approximately 95% of state correctional facilities report providing some form of mental-health treatment (Blitz et al., 2005). In addition, individuals with mental illnesses and substance abuse problems were more likely, by choice, to participate in self-help programs, such as Alcoholics Anonymous, than in general mental-health treatment while incarcerated (Malik-Kane & Visher, 2008). In 2000, 70% of state facilities, with at least one in each state, were screening inmates for mental-health concerns prior to placement to determine inmates’ mental health and emotional status (Adams & Ferrandino, 2008). After the screening process, inmates who were found to have mental-health concerns were sent to a separate mental-health confinement facility, such as a forensic hospital, or to a separate area of the prison to obtain proper treatment (Adams & Ferrandino, 2008).

Once the inmates have been deemed appropriate for treatment, several different options are available to them, depending on the location. Among forensic hospitals, the top two forms of treatment provided are therapy and medication. Approximately 84% of facilities offer counseling therapy, and 83% distribute medications (Beck & Maruschak, 2001). Parker (2006) noted that mental-health interventions available during

incarceration are usually limited to psychiatric medications because of limited amount of space, time, and/or money. Half of the state facilities were found to provide 24-hour mental-health-crisis care, which consists of constant surveillance and increased treatment services, including counseling (Adams & Ferrandino, 2008).

In comparison to mental-health treatment, substance abuse treatment is not as prevalent for incarcerated individuals. Roughly, only 1 of 4 state inmates receives substance abuse treatment. Of the inmates receiving substance abuse treatment, approximately 40% reported they were using drugs at the time of their offense (Blitz et al., 2005). Additionally, 63% of prisoners who are diagnosed with mental-health illnesses used drugs prior to arrest compared to only 49% of prisoners without a mental-health diagnosis (James & Glaze, 2006). These statistics further exemplifies the co-occurrence among the two diagnoses and the increased need for treatment for this population.

According to a prison consensus conducted in the year 2000, the type and amount of treatment provided were diverse among facilities (Manderscheid, Gravesande, & Goldstrom, 2004). Overall, approximately 17,000 of the inmates who were identified as having mental illnesses received 24-hour care (Manderscheid et al., 2004). The majority of these inmates were incarcerated in state-owned prisons rather than held in forensic hospitals or local jails. Therapy for mental-health problems was used by 79% of inmates, with the majority of them being women, and 10% of inmates were receiving psychotropic medications, including antidepressants, stimulants, sedatives, and tranquilizers (Beck & Maruschak, 2001). The use of medications as a form of treatment was most common in

facilities that had a mental-health and medical treatment unit compared to facilities that did not have a separate treatment unit.

However, not all facilities offer these types of services to inmates. Approximately 35% of facilities reported that they did not provide any form of mental-health and/or substance abuse treatment to inmates (Manderscheid et al., 2004). Many of these facilities are considered low security or locally operated jails. About half of these facilities had a policy requiring mental-health screening, assessment, and treatment (Beck & Maruschak, 2001). The least common service available to inmates was a 24-hour mental-health-care unit. The most common service available was medication management and providing assistance to released inmates for obtaining appropriate mental-health services in the community, such as providing a list of providers and steps to take toward obtaining treatment (Beck & Maruschak, 2001; Manderscheid et al., 2004).

The SMR lays down guidelines that delineate how individuals with mental illnesses and/or substance abuse issues are entitled to proper treatment while incarcerated. Consequently, each state has adopted its own standards for treatment for inmates with mental illnesses based on these guidelines. Depending on the jail or prison in which they are incarcerated, inmates receive different forms of treatment. The forms of treatment offered can range from medication management to group and/or individual therapy. These services are available in order to stabilize individuals so that they can function better in the prison or jail environment, to reduce behavioral problems, and to decrease recidivism rates by intervening at incarceration.

Recidivism is usually defined as the tendency to return to previous criminal behavior patterns (Beck, 2001). Two different views on what is considered recidivism have been outlined. The first holds that any new contact with the criminal-justice system, even if it is minor, should be considered a form of recidivism (Beck, 2001). The competing view states that contact with the criminal-justice system is considered a form of recidivism only if a new crime is committed and results in a new sentence (Beck, 2001). Based on these differing definitions, recidivism numbers can change drastically, depending on which definition is used. The first definition that states any new contact with the criminal-justice system is a form of recidivism, is the more commonly used definition.

Recidivism is vital to study, especially when attempting to understand the success of reentry programs. However, reliable recidivism rates can be difficult to track without reliable or uniform data collection. Obtaining accurate and reliable rates often involves following individuals for a number of years; it also frequently requires relying on the data sets obtained by state and national agencies. In 1994, the Bureau of Justice looked at the rearrests, reconviction, and reincarceration of offenders from 15 different states in a 3-year follow-up time span after each individual's release (Langan & Levin, 2002). At the 3-year follow-up point, 67.5% of the prisoners had been rearrested for a new crime, 46.9% were reconvicted for a new crime, and 51.8% were back in prison. The individuals who were back in prison were either resentenced as a result of a new crime that they committed or because they violated a provision of their release (Langan & Levin, 2002).

The second main review of recidivism was the United States Sentencing Commission Study. This study examined the relationship between offenders' sentences and recidivism rates (Nunez-Neto, 2008). A strong association was found between recidivism rates and an offender's criminal history. Both the number of prior convictions and seriousness of the crimes committed increased the likelihood that the offender would reoffend (Nunez-Neto, 2008). The definition of recidivism used in this study had an important impact on the resulting statistics. The recidivism rate was 55% after 2 years when using the general definition for recidivism; however, when utilizing the reconviction definition, only 15% of ex-offenders met standards (Nunez-Neto, 2008). Of special interest was that the authors found that individuals with mental-health problems had much contact with the criminal-justice system post release. Dually diagnosed individuals were noted to have higher rates of recidivism because of criminal activity and lack of follow-up compared to non-substance-abusing, mentally-ill offenders (Hartwell, 2004). In combination, these studies show the high rates of recidivism for ex-offenders and the need for successful reentry programs.

Reentry Programs

In 1994, a 15-state study showed that approximately two thirds of released prisoners were rearrested during a 3-year follow-up period (Hughes, Wilson, & Beck, 2001; Langan & Levin, 2002). The process of reentry appears to have become more difficult for inmates, which may be the result of many of the "get tough" on crime strategies of the 1980s and 1990s. During this time, mandatory sentences increased and the use of parole boards decreased (Listwan, Cullen, & Latessa, 2006). These changes in policing meant that offenders were more frequently required to serve out their full

sentences and were released with no supervision or support in the community. Studies showed that in 1976, 65% of prisoner releases were decided by the parole board, and by 1999, this number dropped to a low of 24% of prisoners leaving the prison via parole board decision-making (Travis & Lawrence, 2002). As a result, many prisoners lacked incentive to prove to parole boards that they could be rehabilitated prior to their release dates. Consequently, many inmates stopped participating in rehabilitative services, such as educational opportunities, while in the institutions (Haney, 2002). Less engagement in rehabilitation services is thought to have resulted in fewer inmates being able to handle the barriers they faced upon release. Policy makers realized this problem and started to understand the importance of implementing services, such as reentry programs, to assist inmates to become better prepared for release after incarceration. The reentry movement signifies an effort to provide social services and adequate resources to offenders as they reintegrate back into the community. The federal government recognized that high recidivism rates were a significant concern, as well as extremely costly, and started to implement initiatives to formulate reentry programs to deal with the large number of prisoners being released back into the community each year (Listwan et al., 2006).

Initiatives implemented for reentry programs. The Second Chance Act of 2007 provides incentives to correctional and community-based organizations to develop appropriate reentry programs (Pogorzelski et al., 2005). This law was signed into effect on April 9, 2008, and authorized federal grants to nonprofit and government agencies to provide assistance during the reentry process. The forms of assistance that qualify under this act include employment, housing, substance abuse treatment, family programming,

mentoring, and additional services that will assist with increased success rates of reentry programs (Wikoff, Linherst, & Morani, 2012).

Many grant programs are available to implement reentry programs. The Department of Justice oversees many of the grant programs that offer assistance to implement reentry programs at the federal level. A federal pilot program known as the Serious and Violent Offender Re-entry Initiative (SVORI) was designed for adult offenders. Later, the Prisoner Re-entry Initiative (PRI) replaced this program and was focused on providing services and assistance during all three phases of offender reentry: prerelease, post release, and during the transitioning process (James, 2011). This grant program also implemented reentry services in juvenile facilities.

The Department of Justice also offers grant programs at the state and local level. The Community Oriented Policing Services (COPS) funded a pilot offender reentry program known as Value-Based Re-entry Initiatives (VBRI; James, 2011). According to the U.S. Department of Justice (2006), part of this program designates or empowers community organizations to serve as liaisons between ex-offenders and the services available in the community, including housing, employment, and treatment providers. Another program is the Weed and Seed Program, which was developed to demonstrate an innovative approach to law enforcement and community growth in order to prevent and control crime and drug abuse. It also connects ex-offenders with community services that will encompass prevention, intervention, and treatment (Dunsworth & Mills, 1999). Different factors are involved when implementing reentry programs to make them successful and meet the needs of the individuals.

Factors of reentry programs. Reentry programs are usually divided into three different temporal phases. The first phase of the program occurs while the offenders are still incarcerated. During this phase, they are provided with services that are congruent with their needs and prepare them for community reentry (Taxman, Young, & Byrne, 2003). The second phase begins as the offenders are released from prison. Ideally, they should continue in treatment services in the community (Taxman et al., 2003). The last phase provides long-term support, aftercare, and relapse prevention to the ex-offenders to address their needs as they obtain stability and settle into society (Taxman et al., 2003). Not all programs implement all of these phases, but research has found that the most effective programs include aspects of all three (Listwan et al., 2006).

Reentry programs can differ in many ways. Depending on the structure of the program, they can vary in the services that are provided and the type of clients served. The main rationale for the programs is to work with the individuals before they are released and to continue to work with them through the transitioning process (Wikoff et al., 2012). Some of the programs will assist persons with individual needs on a topic of their choice, such as employment, while others have a more structured set of services. Overall, reentry programs are most successful when they are able to match the needs of the offender (Wikoff et al., 2012).

Involving the offender's family and community also plays a role in the reentry process. In one study, a majority of ex-offenders with mental-health conditions received some assistance from family members, but reported less emotional and tangible support when compared to other returning offenders (Malik-Kane & Visher, 2008). Successful reintegration into the community should be seen as an interdependent process (Draine et

al., 2005). Based on this point of view, Draine et al. (2005) developed a shared responsibility and interdependent model for understanding community reentry for individuals with mental illnesses who are leaving prison. The model has two units: the individual and the community. The goal is for the individual and community to support the goal of reentry. Doing so will increase prosocial behavior of the individual and allow for successful reintegration. The individual needs to be matched to an appropriate residential community where they can obtain needed resources and then give back resources to the community in return for assistance and acceptance into the community (Draine et al., 2005). Overall, the overarching goal of reentry planning is to transition and integrate the individual back into the community and to pull the community closer toward the individual. Having the individual and the community both involved will eliminate the gap between the person's needs and the community's resources (Draine et al., 2005).

Upon release from prison, inmates will need assistance with learning to structure their time and manage the stress related to transitioning back into the community (Draine et al., 2005). If they do not get assistance, they may be tempted to return to negative impulsive behavior. In addition, they will also need to build work skills to obtain employment and meaningful activity (Draine et al., 2005). Communities will need to offer resources in response to the needs of the residents. These resources could include housing, employment, schools, childcare, social services, medical services, and religious and spiritual opportunities (Draine et al., 2005).

Fundamental components of successful reentry programs. While much has been written about reentry service components that should be implemented to assist with

a smooth transition into the community, little empirical research has been conducted to establish which service components actually are effective and work. The University of Maryland conducted research for a National Institute of Justice report to Congress and coined the phrase *what works* to describe factors that are considered effective. This paradigm was adapted to the concept of offender reentry in 2003 for the St. Louis University Study (Seiter & Kadela, 2003). The what works paradigm attempts to identify programs, based on a scoring system, that have or have not proved to have an impact on reentry (Seiter & Kadela, 2003).

Several factors were found to be fundamental components for successful reentry programs. One factor was employment assistance, with research finding that if ex-offenders were able to find stable employment, they were much more likely to succeed in rehabilitation than those who were currently unemployed. Overall, the vocational and work programs that were studied showed to be effective in reducing recidivism and allowing the ex-offender to obtain the skills needed to be employed (Saylor & Gaes, 1992, 1997; Turner & Petersilia, 1996).

Another factor that has proved effective and necessary in reentry programs is drug and alcohol treatment. The most successful programs showed that individuals who were participating in post release transitional housing programs with drug and alcohol treatment components committed fewer and less severe offenses and had a lower recidivism rate compared to those who were not participating in a program with these treatment components (Department of Criminal Justice, 2001). Generally, intensive treatment obtained while incarcerated combined with aftercare treatment has shown to

reduce substance abuse among these individuals, especially those who have a long history of substance abuse problems (Department of Criminal Justice, 2001).

Transitional housing is another component that has a fundamental impact on successful community reintegration. In addition to lowering recidivism rates, these types of programs were also able to help individuals hold a job, be self-supporting, and participate in self-improvement programs (Seiter & Kadela, 2003). Those who were not able to obtain these services, particularly employment, were less likely to be able to support themselves financially and needed to turn to other activities, sometimes illegal, for sources of income (Malik-Kane & Visher, 2008). Transitional housing allowed the ex-offenders to have stability and transition more efficiently and effectively into the community. While educational programs were found to be effective in increasing academic achievement scores, they were found to have little impact on the rates of recidivism (Seiter & Kadela, 2003).

Useful information can be learned about successful components of reentry programs through the what works research agenda. However, like any other form of research, the what works studies also have limitations (Seiter & Kadela, 2003). Only 32 studies met selection criteria for the review study. Only 19 of those programs contained a control group, and only two of those 19 used random selection (James, 2011). The limitations of the what works studies has raised the question or concern as to whether the findings outlined as effective in this literature really can be attributed to the effectiveness of the programs. Additionally, many of the programs that were studied used recidivism as the only outcome measure (Petersilla, 2004). The evaluations of the review study should have included such constructs as treatment adherence, vocational success, and/or

housing stability and ideally should have been based on more rigorous research

principles, such as random assignment. However, real experimental design with true randomization to an intervention versus a control condition is very difficult to conduct in legal settings. Additionally, multiconstruct evaluations can become expensive and time consuming to carry out. These factors forces policy makers to make a difficult decision concerning whether to fund additional evaluations of these programs (James, 2011).

Although the review conducted by Seiter and Kadela (2003) had limitations, some patterns did emerge from the research. The characteristics shared by the majority of the successful programs are as follows: (a) they started during institutional placement, but took place mainly in the community, (b) they were intensive in nature and lasted at least 6 months, (c) they focused on services based on risk-assessment classifications to identify the individuals at high risk of recidivating, and (d) they utilized treatment programs that use cognitive- behavioral treatment techniques. Furthermore, the more successful treatment programs matched therapist and programs to the specific needs and characteristics of the offenders (Petersilla, 2004). The programs that share this combination of components were found to reduce the overall likelihood of recidivism.

Several forms of reentry strategies have proved effective with implementing successful reentry into the community for this population. The first strategy is discharge services. Discharge planning contains information that is specific to the inmate's needs to assist with employment, community-based treatment, housing, and financial support (Lurigio et al., 2004.). Inmates with mental illnesses can be forced to serve out their entire sentences, rather than obtain probation, as the result of the absence of an approved discharge plan. The absence of an approved discharge plan can be caused by the lack of

services available to them in certain geographic areas. Additionally, more than one third of correctional facilities provide no support to inmates who are mentally ill (Beck & Maruschak, 2001). Without this form of support, these individuals are at a higher risk of decompensation, violation of conditions of release, and returning to prison (Council of State Governments, 2002).

In order for discharge planning to be effective, post-release services that are offered need to be intensive and ongoing (Lovell et al., 2002). A study of Washington State Prison showed that 73% of the prisoners released received mental-health services (Lovell et al., 2002). However, few received meaningful levels of care during the first year after release, and more than half of them were rearrested for new charges during this year (Lovell et al., 2002).

In addition to discharge planning, another strategy that has proved effective for successful reentry is the use of parole in the form of mandated drug treatment. Studies have shown that when using court orders in the criminal-justice system, enrollment and participation in drug and alcohol treatment programs increase (Lurigio, 2002). It has also proved to be effective with reducing overall criminal activity. Parole conditions are designed to provide the structure and boundaries that the ex-offenders need in order to maintain a healthy, stable lifestyle and focus on their recovery (Massaro, 2003).

The last strategy implemented during the reentry process is case management. Case management services have proved effective with a wide array of services, including mental-health and substance abuse treatment programs. Case management is designed to link ex-offenders to resources in their community that will benefit them. Agency communication and collaboration is a key component for ex-

offenders' ability to overcome many of the barriers that they may face upon reentry. The case management program will assist the ex-offender with obtaining a stable role and tenure in the community by working with them to obtain financial support, vocational training, insurance coverage, housing, positive social activities, medical treatment, and mental-health and substance abuse treatment (Lurigio et al., 2004).

The ideal case management strategy has been noted to be a multidisciplinary team approach (Peter & Hills, 1997). The team should consist of treatment providers, parole agents, and case managers. All of these members must work collaboratively to allow for a seamless transition. Each member should be aware of the functions and responsibilities of the other members and have good communication skills. Having a multidisciplinary approach will assist the ex-offender with assessing, adhering to, and engaging with treatment programs and with decreasing chances of crisis, relapse, decompensation, and, most importantly, recidivism (Lurigio et al., 2004).

Challenges to achieving successful reentry. The rationale for implementing reentry programs for individuals at high risk for recidivism is to assist the ex-offenders with navigating their transition back into the community and to allow them to achieve stability. Stability is promoted through employment, housing, treatment services, and appropriate social support systems, which in turn may reduce the likelihood of the ex-offender turning to illegal acts to achieve their goals. Once released from jail and/or prison, ex-offenders will need to overcome several major challenges in order to successfully integrate back into the community. For example, most ex-offenders do not receive public assistance, such as food stamps, cash assistance, and/or medical assistance, while incarcerated or after release to assist them with community integration (Wikoff et

al., 2012). Two other pressing challenges that occur include finding and obtaining affordable and stable housing and securing and maintaining employment (Baillargeon, Hoge, & Penn, 2010). Ex-offenders also face legal barriers, including bans on public assistance, housing restrictions, limited transitional-housing options, obtaining employment because of their criminal records, and obtaining proper state identification (Wikoff et al., 2012).

Overcoming these challenges is often contingent on support from family and friends, as well as access to the appropriate social networks to link to services they may need (Baillargeon et al., 2010). Several risk factors have been identified that increase the likelihood that ex-offenders will not successfully reintegrate into the community. These factors include age, race, gender, substance abuse, negative peers, criminal history, economic difficulties, minimal vocational abilities, antisocial behaviors, gang membership, and mental-health issues (Wikoff et al., 2012).

Individuals with mental-health diagnoses released from prison experience additional challenges to successful reentry. Ex-offenders with mental-health conditions were more likely to experience homelessness upon release and were found to have difficulty finding and maintaining employment (Solomon, Dedel Johnson, Travis, & McBride, 2004). Additionally, these individuals reported a higher likelihood of residing with former offenders and substance abusers, which had an impact on their reentry success (Metraux & Culhane, 2004). Individuals who are dually diagnosed with mental-health and substance abuse concerns have even more difficulties overcoming these challenges (Hartwell, 2004).

Recently released offenders are also unlikely to obtain proper treatment services for their mental-health and/or substance abuse needs because of lack of insurance. Incarcerated individuals lose their Medicaid benefits, and upon release from incarceration, the individuals will need to go through the entire reapplication process in order to get their benefits reinstated (Substance Abuse and Mental Health Services Administration [SAMHSA], 1999). This process may take as long as 3 months, placing the ex-offender, without appropriate mental-health and/or substance abuse treatment, at risk of decompensation (SAMHSA, 1999).

Perspectives on Community Reentry from Offenders and Ex-Offenders

Although quantitative research has looked at the effectiveness of reentry programs and the key components for their effectiveness, the viewpoints of the individuals actually participating in those programs may be able to shed additional light on the topic. In order to more deeply explore what is helping and/or lacking from the offender's or ex-offender's perspective, interviews have been conducted with these populations. Individuals who have been through this process have completed surveys about their perceptions on all three steps of the process: prerelease, post release, and long-term care.

Studies have indicated that mental-health and medical care is available to this population while incarcerated. However, surveys completed by state and federal inmates revealed that the majority of inmates expressed that the medical care received was not adequate for their needs and the availability of the services was poor (Visher, Naser, Baer, & Jannetta, 2005). Inmates reported that they would experience long wait times in order to see a physician and were often met with insensitivity and uncaring treatment

(Visher et al., 2005). Another research study has shown that inmates have similar concerns when seeking mental-health and/or substance abuse treatment as compared to those of the general population (Williams, Skogstad, & Deane, 2001). Similar to the general population, treatment was more likely to be sought when psychological distress was experienced as acute. The main barrier found to affect treatment seeking was the concern of stigma. Williams et al. (2001) reported that inmates were satisfied with the types of treatment services that were provided and were willing to participate in the treatment programs, but also reported that they frequently encountered insensitive treatment providers.

One of the few qualitative studies that looked into the experiences of male offenders with mental-health problems found additional information regarding their concerns and expectations regarding leaving prison and starting the reentry process (Howerton, Burnett, Byng, & Campbell, 2009). During these interviews, which were conducted while the individuals were still incarcerated, the inmates discussed their problems, concerns, and beliefs regarding their eventual release. The concept of the “revolving door” was mentioned frequently during these interviews. Inmates who had been previously incarcerated expressed that the lack of prerelease planning and available after-care services resulted in many offenders, including themselves, ending up right back in prison (Howerton et al., 2009). The individuals felt that the odds were stacked against them and expressed hopelessness regarding their ability to overcome all the barriers they would face upon release. These study results highlight how past experiences and observations have shaped offenders’ attitudes and cognitions that play a key role in the prerelease process and can influence the outcome following release. Individuals have

expressed that they need to be motivated to transition well and accept responsibility but that help from society is needed as well (Howerton et al., 2009). The consensus was that more assistance needed to be provided both pre and post release, for example, assistance linking to resources, such as reentry programs, to allow these prisoners to start their transitioning process (Howerton et al., 2009).

When asked about their post-release experiences, released offenders expressed they were most in need of several types of services that would assist them with a smoother transition. Assistance with housing, education, job training, food, clothing, employment, services to obtain a driver's license and insurance, and health-related services were the most frequently noted areas of assistance required (Visher & Travis, 2011). Individuals also indicated a need for services that would assist them with changing past behavior patterns, such as mentoring, anger management, parenting skills, social skills, child care assistance, and financial skills (Visher & Travis, 2011). Surveyed male inmates stated that they did not obtain the needed information from the criminal-justice system about programs or agencies in the community prior to release. As a result, individuals felt they were not able to obtain the appropriate medical or mental-health treatment they needed. Instead, they relied on their family and friends to assist with linking them to resources or would go to the local emergency room to obtain the medication that they needed upon release (Visher et al., 2005).

Ex-offenders have expressed that reentry programs are needed and named the barriers that should be addressed in these programs. They stated that one of the biggest barriers to successful reentry was the support of the community, although specific examples were not described in detail. On the positive side, ex-offenders expressed that

when participating in a reentry program, they felt that more services were available to them compared to those available for ex-offenders not participating in a program (Visher & Travis, 2011). They felt that they were able to meet with a case manager and work on their needs and attempt to transition back into the community and obtain stability while in the programs. During interviews conducted approximately 30 days post release, 57% of ex-offenders expressed that they had a reentry plan (Visher & Travis, 2011). However, the overwhelming area of remaining concern was the need for mental-health and substance abuse treatment, despite the presence of reentry plans. Approximately one third of prisoners who were being released from prison reported that substance abuse and mental-health treatment was among the most important needs to them and was the most difficult to obtain (Visher & Travis, 2011). Limited information was gathered as to why these ex-offenders felt that obtaining mental-health and/or substance abuse treatment would be the most difficult aspect of reentry.

In addition to the release of individuals with a mental-health diagnosis, approximately one quarter of those released into the community have an undiagnosed mental-health condition (Malik-Kane & Visher, 2008). Once released from prison, the majority report an immediate need for treatment based on severity of their mental-health symptoms. Approximately 6 of 10 offenders with known mental-health conditions received treatment while incarcerated; however, once released, the mental-health treatment rates declined by 50% and stayed consistent 6 to 10 months post release (Malik-Kane & Visher, 2008). Access to medications was a specific concern for several reasons, including lack of Medicaid benefits, the cost of medication, an inability to get medication prescribed, and being told by a physician in the community that they no

longer needed the medication (Malik-Kane & Visher, 2008). Lack of health coverage is a significant barrier that inhibits released inmates from obtaining proper mental-health and substance abuse treatment and prescription medications.

Van Olphen et al. (2009) surveyed female inmates and found that staying sober from drugs and alcohol was also a significant concern to women. These women expressed that they were not properly prepared for their release and obtained only minimal information regarding what could have assisted them to remain sober from drugs and alcohol. Relapse to substance use, therefore, was cited as a significant barrier to successful reentry (Van Olphen et al., 2009). Many women expressed that they returned to drug use upon release from prison as a result of the lack of substance abuse treatment available while incarcerated. When services were available, they were predominantly group treatments that focused on Alcoholic Anonymous principles and other self-help groups, but availability of one-on-one intensive drug and alcohol treatment was minimal (Van Olphen et al., 2009).

Outcomes and Effects of Community Reentry

The transition from prison to the community can have multiple negative outcomes for the ex-offenders as previously outlined, including serious health consequences. Upon release, mortality rates were 3.5 times higher than would be expected in similar demographic groups (Binswanger et al., 2011). The leading causes of death for this population included drug overdoses, cardiovascular disease, homicide, suicide, motor vehicle accidents, and cancer (Binswanger et al., 2011). When interviewing ex-offenders about this information, the authors found that certain challenges arose during the reentry process that elevated individuals' chances for negative health consequences. Ex-

offenders expressed that the risk of contracting a disease was greater for them because they were homeless or staying in shelters. Ex-offenders with mental-health concerns expressed that having medical-health problems in addition to mental-health problems was a concern because of a lack of resources for treatment (Binswanger et al., 2011). They expressed having trouble linking with services and traveling to their appointments, which elevated symptoms and caused more distress. Linking with services and transportation continues to be an enormous barrier for this population.

Understanding how individuals in general, both the general public and ex-offenders, find their way into the system and gain access to appropriate treatment, especially mental-health and/or substance abuse treatment, is helpful. One can look at how individuals come to enter mental-health treatment in several ways: choice, coercion, and muddling through (Pescosolido, Gardner, & Lubell, 1998). These authors referred to choice as the time when individuals decide on their own that they want to or at least agree to the treatment need identified. Coercion means that resistance to treatment is active throughout the entire process, but some kind of mechanism is exerted to force individuals into treatment. Muddling through refers to individuals ending up in treatment even though they did not actively resist or make an active choice (Pescosolido et al., 1998). The last group does not actively engage in or resist treatment; they just go with the flow.

The goal of setting up individuals with services or linking them to services in the community upon release is to increase their active choices and reduce coercion, either real or perceived. Individuals, especially those who have been marginalized, should feel that they have a voice and play an active part in treatment decision-making, rather than

being forced into another situation that they feel they are unable to determine and/or control. Being knowledgeable about obtaining mental-health treatment can empower this population to obtain the services they feel they want and need. One other significant barrier that individuals, especially those who have a criminal background and mental-health and/or substance abuse issues, may encounter upon reentry is the experience of being stigmatized. Different types of stigmatization can occur for this population and place them in uncomfortable and difficult situations when working toward successful transitioning into the community.

Stigmatization

Individuals diagnosed with mental illnesses face many challenges. In addition to managing possible symptoms and the stressors that exist in individuals' environments, another significant challenge is the stereotypes and prejudices that many people encounter as a result of misperceptions about mental illnesses (Corrigan & Watson, 2002). The stereotypes and misperceptions can fall into two different categories and will affect the individual differently. The first category is public stigma. Public stigma is the reaction that the general population has toward individuals with mental illnesses (Corrigan & Watson, 2002). Public stigma consists of beliefs and attitudes that individuals with mental illnesses are dangerous, unpredictable, and violent (Stuart, 2003). The second category of stigma is known as self-stigma. It includes conscious and unconscious stereotypes and misconceptions that individuals with mental illnesses have internalized and, hence, hold about themselves. It is characterized by negative feelings resulting from the individual's experiences of negative social interactions (Corrigan & Watson, 2002; Livingston et al., 2011).

The general public derives many of its beliefs about individuals with mental illnesses from the media and film industry. These sources have portrayed individuals with mental illnesses in highly stereotyped ways, for example, as being dangerous people who should be feared by the public and who are personally responsible for their mental illnesses, implying that mental illness is a result of character flaws; as being irresponsible and unable to make their own decisions; and/or as being childlike and helpless (Brockington, Hall, Levings, & Murphy, 1993; Gabbard & Gabbard, 1992; Mayer & Barry, 1992; Taylor & Dear, 1980). Individuals have also linked mental illnesses with drug addiction, prostitution, and criminality (Skinner, Berry, Griffith, & Byers, 1995). Negative and inaccurate stereotypes have been shown to result in discrimination in the form of withholding help, avoidance, engaging in coercive treatment, and segregated institutions (Corrigan & Watson, 2002).

Three different approaches have been proved to assist with decreasing public stigma: protest, education, and contact. Protest attempts to diminish negative attitudes toward this population and promotes more supportive attitudes by using facts (Corrigan & Watson, 2002). Additionally, studies have proved that participation in educational programs focused on mental illnesses and regular contact with this population leads to more positive attitudes about individuals with mental illnesses (Corrigan et al., 2001; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). Finally, when the general public has contact with an individual with a mental illness who is stable, has a job, and is considered a good neighbor; stereotypes are challenged and can be changed.

When these individuals continue to face public stigma, they may start to internalize these beliefs and see themselves as less valued and develop self-stigmatizing

beliefs that may, for example, elevate symptom severity and lead to poor treatment adherence (Fung & Tsang, 2010; Fung, Tsang, & Corrigan, 2008). It may also cause the person to have low self-esteem, poor quality of life, and lessened confidence in their abilities (Bjorkman & Svennson, 2005; Holmes & River, 1998; Link, Castille, & Stuber, 2008). Self-stigma will be different depending on the individual and the experiences that he or she has had.

When an individual with a mental illness is released from the criminal-justice system, he or she often faces additional discrimination because of the addition of a criminal or forensic label (Livingston et al., 2011). This criminal label is considered a barrier to successful community integration and causes problems when attempting to obtain housing, employment, and treatment. Through qualitative interviews, this population expressed self-stigmatizing beliefs, largely because they felt that others see them as a threat and dangerous and therefore had experienced being treated like a group of criminals (Livingston et al., 2011). This experience may affect the way that they perceive all forms of mental-health services and thus will impact their willingness to obtain mental-health and/or substance abuse treatment.

Individuals dealing with mental-health concerns, a history of criminal behavior, and substance abuse problems can be considered to have a triple stigma. All three of these labels can have an impact on how a person is viewed by others and consequently may view him or herself. Individuals with a dual diagnosis of mental-health and substance abuse concerns have increasingly become involved in the criminal-justice system, for a variety of reasons. One of these reasons is stigmatization by the community, for example, when other individuals in the community contact police if they

feel unsafe in their presence (Hartwell, 2004). As a result of a dual diagnosis, these individuals often are not considered preferred candidates for rehabilitation services and residential facilities (Hartwell, 2004). This population faces multiple barriers upon reentry and struggles significantly with transitioning back into the community.

Winnick and Bodkin (2008) found that individuals in the criminal-justice system perceived their chances of being able to transition back in the community and gain acceptance as low; instead they anticipated that the community as a whole would reject them. In their study, they found that individuals in the criminal-justice system felt that they would not be treated like everyone else and would be given a different set of standards to live by. The biggest concern expressed was how this perceived treatment would affect their ability to gain employment. Study participants also expressed concern over the chance that the public stigma they feared they were about to face upon reentry might change over time (Winnick & Bodkin, 2008).

Many ex-offenders will likely escape negative social reactions by withdrawing from the community based on their concerns about having to encounter public stigma from both their general community and treatment providers post release (Winnick & Bodkin, 2008) These individuals, however, continue to spend time with support systems they feel comfortable with, including other ex-offenders, which has shown to increase their chances of recidivism (Winnick & Bodkin, 2008). Ex-offenders have expressed that they feel more comfortable with people who are like them instead of having to face public opinion and explain their actions.

This population also feels that the concept of public stigma extends to family and friends. Even the individuals who they felt were the most supportive are thought to have

developed a negative view toward them (Winnick & Bodkin, 2008). This stigma causes even greater difficulty for this population, who wants to feel hopeful that they will have a successful reentry into community. This difficulty with reentry is based on the real or perceived fear of stigma and discrimination not just from society, but also from their loved ones.

Studies have also looked at the difference in discrimination based on the gender of offenders. Some of the major differences that have been found are that female offenders returning home from prison deal with a higher likelihood of mental-health conditions, medical conditions, economic marginality, and substance abuse issues (Lebel, 2011). Women are also more likely than men to experience gender discrimination in areas of employment (Flores & Pellico, 2011; Lebel, 2011). Additionally, differences exist in perceptions of discrimination based on gender. Women felt that they were released from prison with no support system to assist them with transitioning back into the community (Flores & Pellico, 2011). They expressed feeling that they were being held to a different standard because of their gender. For example, they noted that society viewed incarceration for drug use or violence as understandable for a man but not for a woman. Instead, society judged women as having committed some moral crime that men were not accused of (Van Olphen et al., 2009).

An area that women found especially difficult to deal with after release involved their role as a parent and the associated discrimination that they may experience as an ex-offender parent. Recently released women have expressed concern with stigma that they perceived to be expressed toward them by their own children. They reported experiences of painful separation from them while they were incarcerated and, upon release,

perceptions that they were not welcomed back home (Flores & Pellico, 2011). These women also reported struggling with the public stigma that impacted their ability to be a parent and to be accepted, for example, during involvement with the Parent Teacher Association (PTA) and church activities (Flores & Pellico, 2011). Mothers reported that stigmatizing beliefs not only affected themselves, but also affected their children. Children may not be allowed to play with their friends once the friends' parents know that the child's mother is an ex-offender. Children may also start to experience forms of stigma and discrimination because of their connection with the ex-offender (Flores & Pellico, 2011). These examples exemplify how stigma toward one person, the ex-offender, can also affect the people around the ex-offender.

Individuals who are incarcerated will face many challenges upon release. They will need to overcome many barriers in order to transition successfully back into the community. Some of the challenges that will need to be overcome include obtaining housing, employment, and treatment services as needed. Many of the ex-offenders released from prisons and/or jails have been diagnosed with mental-health and/or substance abuse issues. These behavioral-health concerns exacerbate the number of barriers that a person will have to surmount to successfully return to society after incarceration. Several policies have been enacted by the government, such as implementing reentry programs to work with this particular population. However, additional research needs to be conducted to evaluate the effectiveness of these programs. Ultimately, the research on reentry programs is lacking studies of clearly delineated, adequate, and specific reentry policies and strategies that agencies use to aid the reentry process. Ideally, reentry program research needs to be done by completing

program evaluations and program case studies that review the program policies currently in place and their effectiveness. Additionally, interviews of the management, staff, and clients will also add beneficial information about the programs and reentry process.

In addition to facing tangible barriers, this population also faces discrimination caused by stigmas that they have experienced and possibly internalized because of their history of mental illnesses, addictions, and criminal backgrounds. When all of these challenges affect an individual, he or she will have trouble succeeding and will have a higher probability of not transitioning properly and eventually of experiencing recontact with the criminal-justice system.

In order to better understand the process of community reentry and the challenges that individuals face during community reintegration, more research needs to be completed on the attitudes and beliefs of ex-offenders who are currently experiencing these challenges. Understanding the perceptions of ex-offenders who are dually and triply affected, which includes involvement in the criminal-justice system, mental-health concerns, and/or substance abuse issues, is important. Additionally, the effects of perceived stigma and/or self-stigma must be understood in regard to the reentry process, given the possibly important role stigma plays with seeking assistance, especially treatment assistance. Overall, this additional research will allow for better insight into the process from the perspective of ex-offenders and for a deeper understanding of the strengths and weaknesses of reentry programs that are currently being implemented. Gaining this perspective is important to an understanding of not just what is available but what services are perceived as helpful and are actually used. Furthermore, this information will assist professionals in the mental-health and

criminal-justice fields to help this population overcome these barriers, especially with regard to mental-health and addictions treatment service provisions both inside the jail and prison and post release. Finally, this information might assist policy makers with addressing individuals' needs pertaining to their medical, employment, parenting, and living requirements upon release from incarceration.

Purpose of the Study

The current study was conducted with ex-offenders who were currently in reentry programs in order to explore their experiences of stigmatization, as well as their access and adherence to mental-health and substance abuse treatment. A better understanding of what works and does not work from the viewpoint of individuals actively engaged in the process of reentry is needed in order to assist them with successful reentry. The research questions considered in this study focus on ex-offenders' opinions of and experiences with reentry programs, an exploration of factors that influence ex-offenders' reasons for seeking mental-health and/or substance abuse treatment services as part of their reentry process, and inquiry into the role of stigma (public and self) in seeking services following discharge from jail.

Research Questions

This study aimed to answer the following research questions:

1. What are ex-offenders' views and/or thoughts regarding reentry programs?
2. How do services received in jail impact decision-making about entering into reentry programs?
3. What influences ex-offenders' choices to seek mental-health and/or substance abuse treatment services as part of their reentry program?

COMMUNITY RE-ENTRY

37

4. What role does perceived public and self-stigma play in seeking services following discharge from jail?

Chapter 2: Method

Overview

The purpose of the present study was to gain a better understanding of the attitudes and beliefs towards mental-health and/or substance abuse treatment access and adherence from ex-offenders in reentry programs and of the role that stigma played in these considerations. This study used a qualitative research design based on grounded-theory methodology. A single interviewer collected data in a narrative format. These narrative interviews were analyzed using grounded-theory methodology to explore the different perceptions of the ex-offenders and professionals. This research was important to better understand the personal belief sets of these individuals on various topics linked with the reentry process. The topics explored included the thoughts and views of ex-offenders and professionals about reentry programs and how services received while incarcerated impacted their decision-making regarding entering the reentry program. Additional topics explored were the influences that affect ex-offenders' choice to enter mental-health and/or substance abuse treatment while in a reentry program and how perceived public and self-stigma have played a role in their choice to seek services following discharge from jail. The overall concern of the data analysis was to understand ex-offenders' and professionals' conceptualizations of mental-health and/or substance abuse treatment and the successes of and/or barriers to the reentry process.

Research Design and Design Justification

Qualitative research was used to produce descriptions and/or explanations of data obtained. The primary aim of this form of research is to give voice to those whose experiences tend to be less researched or misunderstood. It therefore focuses on the

human experience from the individual's own point of view and occurs in naturalistic settings (Baker, Wuest, & Stern, 1992). This type of research allows researchers to identify, analyze, and synthesize data into themes that emerge from participants' narratives. This methodology uses an inductive process, which adds insight, conceptualization, theory formulation, and a description of the interest at hand to the current body of literature.

Grounded-theory methodology has proved to be a popular approach to qualitative research (Orford, 1995). This type of methodology is useful when developing theoretical models from unstructured data from both mental-health-service participants and providers (Carrick, Mitchell, Powell, & Lloyd, 2004; Clegg, Standen, & Jones, 1996). This method is generally used to discover concepts of social and psychological processes in order to better understand their function (Baker et al., 1992). Grounded-theory methodology differs from other forms of qualitative research in that the theory is created during the data analysis, and thus the validity of the created theory is grounded as the data supporting the theory increase (Corbin & Strauss, 2007). The theory itself is developed throughout the research process as more data are collected and analyzed. The theory continues to change according to what the data analysis dictates (Corbin & Strauss, 2007). Grounded-theory methodology is an inductive approach to research, with the purpose of discovering a theory as opposed to verifying one (Corbin & Strauss, 2007).

Several key concepts differentiate grounded theory from other forms of qualitative methodology. Other forms of qualitative research collect all the data and then analyze them; however, when using grounded-theory methodology, the collection and

analysis of data must happen simultaneously in order for the research to be conducted properly. Collecting and analyzing data simultaneously allows the development of a theory to occur based on the data collected (Holton, 2010). This theory must then be checked back against the data to verify validity. As more and more data are obtained, the researcher must continue to validate the theory by checking the new data collected against it to assure that it continues to be valid (Holton, 2010).

One key element of grounded theory is the creation of categories. A category is a group of concepts that are grouped together (Ponterotto, 2010). Within a category may be subsets that have different properties and further qualify and group the data. Each subset could then be broken down into additional subsets as needed. When the researcher is creating categories, the process involves finding redundancies in the data that create and form different categories (Ponterotto, 2010). The researcher then conceptualizes the data received and determines the aspect of the theory that needs to be explored further. The researcher also continues to look for categories of the developing theory that may need to be verified. The final step in conducting a grounded-theory analysis is coding. Grounded theory has three main variations of coding: open coding, axial coding, and selective coding (Bitsch, 2005).

Open coding is a procedure for developing categories of information. During this process, the data are coded in major categories and labels are applied to them. The categories are created by the researcher from the identification of reoccurring themes. The themes must be relevant and significant to the development of the theory (Bitsch, 2005; Strauss, 1987; Strauss & Corbin, 1990). After open coding is completed, the next step is axial coding. This coding procedure explores the relationships among all

the different categories created and connections they may have (Bitsch, 2005; Strauss, 1987; Strauss & Corbin, 1990). Core codes, or main ideas, from each category are developed and applied to the main theoretical base. Through this process, a general theme is found that creates the theory by developing the concepts through linking all the themes from all the categories (Bitsch, 2005; Strauss, 1987; Strauss & Corbin, 1990). The researcher's main goal during this step is to create a theoretical model in which interrelationships are identified and verified by the data obtained (Bitsch, 2005; Strauss, 1987; Strauss & Corbin, 1990). The last step in the coding process is selective coding. This step proves to be the most difficult for many researchers. During this step, core categories must be identified. The categories are examined to insure that they are applicable to the theory that is being developed. If the data do not fit the category or are insufficient, selective coding attempts either to allow the researcher to increase the data amount to increase validity or to eliminate the category altogether (Bitsch, 2005; Strauss, 1987; Strauss & Corbin, 1990).

Grounded theory was used because of its uniqueness compared to other forms of qualitative research and to learn more about any theory that will guide the understanding of the phenomena at hand. Grounded theory is an evolving method that continues to grow as data are collected. The data and analysis occur concurrently and are based on a comparative model. This process sharpens the focus of the study, allowing categories to develop and codes to be properly fitted together to develop a theoretical model and overall conceptualization (Baker et al., 1992). This process was determined to best capture the evolving and complex nature of the mental-health and substance abuse treatment decision-making process for ex-offenders in a reliable and valid framework.

Participants

A total of 11 participants were included in the study, five of whom were professionals and six of whom were ex-offenders. The professionals were all male law enforcement officers from the Scranton, Pennsylvania, area. The number of years spent working with the population ranged from 10 to 20 years. The ex-offenders were all Caucasian men residing in Northampton and Lehigh counties between the ages of 21 and 40 years. The level of education completed by the ex-offenders prior to incarceration ranged from not completing high school to high-school graduate/GED. All but one of the ex-offenders did not have previous mental-health and/or substance treatment prior to incarceration. Four of the ex-offenders are currently employed full time and the other two are currently unemployed and looking for employment (See Table). The sample of convenience was recruited by handing out flyers to friends, family, and coworkers who had contact with either of the participation groups identified.

Table

Ex-Offenders' Demographic Information

Age	Relationship status	No. of children and age of child(ren)	Highest level of education	Job status pre/post incarceration	Living situation pre/post incarceration	Previous mental-health/substance abuse treatment
30	In relationship	1 child, age 7	High-school graduate/GED	Full-time/ Full-time	Own/Own	No
40	In relationship	4 children, ages 17-21	9 th grade, not graduated	Full-time/ Unemployed	Rent/Rent	No
30	Single	2 children, ages 3-6	High-school graduate/GED	Full-time/ Full-time	Rent/Rent	No
30	Single	1 child, age 2	High-school graduate/ GED	Unemployed/ Full-time	Rent/ Living with someone	No
21	Single	No children	High-school graduate/ GED	Unemployed/ Full-time	Living with parents/ Living with parents	No
29	Married	4 children, ages 2-11	9-12 years, not graduated	Unemployed/ Unemployed	Living with mother/ Rent	Yes

Participants in the ex-offender group were screened according to the following inclusion criteria: participants (a) were receiving services from a reentry program, (b) were at least 18 years of age, (c) could communicate in English, (d) were male, (e) were first-time offenders and recently released from jail, and (f) met the conditions for a serious mental-health problem (depression, bipolar disorder, any type of schizophrenia, anxiety, borderline personality disorders, psychosis) and/or substance abuse disorder per self-report. Participants were excluded from the study if they did not meet the inclusion criteria. Potential participants were screened for inclusion and exclusion criteria through an interview with the researcher.

Participants in the professional group were screened according to the following inclusion criteria: participants (a) currently had professional contact with male ex-offenders who have received services from reentry, mental-health, and/or substance abuse treatment programs, (b) were at least 18 years of age, and (c) could communicate in English. Participants were excluded if they did not meet the inclusion criteria. Potential participants were screened for inclusion and exclusion criteria through an interview with the researcher.

Recruitment

Eighteen facilities were contacted by phone or e-mail to ask them to hang or hand out flyers between June 2015 and December 2015. The facilities ranged from reentry programs, probation offices, mental-health county courts, churches affiliated with substance abuse and reentry assistance, and community mental-health and/or substance abuse treatment centers. These facilities were located across multiple counties, including

Philadelphia, Montgomery, Chester, Delaware, Lehigh, Northampton, Berks, Monroe, and Lackawanna. Of the 18 facilities contacted, five were able to hang or pass out the recruitment flyer between June 2015 and August 2015, and one reentry program declined to participate in the study in September 2015. The researcher did not get a response from any of the 12 remaining facilities after trying to contact them at least two times per month via e-mail and phone calls. As a result of not getting any responses to the flyers that were hung up and handed out, a stipend for participation was added to the study in February 2016 and professionals who were currently working with this population were recruited. The researcher handed out the flyers to friends, family, and coworkers who had contact with either of the participation groups identified. The flyers contained information about the purpose of the study, and interested individuals were asked to call a designated phone number to schedule an interview with the researcher to have the study fully explained to them, confirm inclusion criteria, and complete the informed consent. After the informed consent form was signed, the researcher confirmed the eligibility criteria and scheduled individual interviews with each person.

Measures

This qualitative study used a brief demographics background questionnaire and semi structured interview format developed by the researcher for both participant groups. Examples of questions included in the ex-offender demographic questionnaire included level of education, marital status, any previous mental-health and/or substance treatment, living situation pre and post incarceration, and job status pre and post incarceration. The professionals' demographics questionnaire asked about occupation and years spent working with this population. Every participant was required to complete the

brief demographics background questionnaire and engage in a semi structured interview.

Data obtained from the interview were considered descriptive and served as the basis for analysis. The interview questions were designed to produce information regarding the participants' perceptions of the reentry process and/or mental-health and/or substance abuse treatment. Some examples of the interview questions included, "What are your thoughts regarding the re-entry program you are participating in?" "What have been your experiences been like so far during your involvement with the reentry program?" "Did you choose to go to mental-health and/or substance abuse treatment as part of your reentry process?" "What have been your experiences been like so far during your involvement with mental-health and/or substance abuse treatment?" and "Do your family, friends, and associates know you are in a mental-health and/or substance abuse program?" (See Appendices A, B, C, and D for brief demographics background questionnaire and interview questions).

Procedure

The interviewer is a graduate doctoral-level student who has taken at least one course in research methodology. Interviews were conducted at a public location in the community of the participant's choice. The interviewer sat across from the interviewee and placed a digital device between them on the table for recording purposes. Verbatim answers were recorded with a "Voice Record" digital application. Prior to questioning, the interviewer reminded the participants that participation in the study was voluntary and reviewed the consent form. The semi structured interview consisted of seven questions, as well as prompts in order to elicit richer detail and content from the narrative. The demographic questionnaire was completed at the end of the interview. At the conclusion

of the interview, participants were thanked for their time and given \$20.00 cash compensation for participation. The interviews lasted approximately 30 minutes and included the semi structured interview and completion of the demographic questionnaire. After completing all of the interviews, three raters and the researcher agreed on a set of codes that was used for further analysis.

Recordings were transcribed verbatim by the researcher after all interviews were completed. Three ex-offender transcripts and two professional transcripts were read three times by the lead investigator and twice by each of the three subsequent raters. The transcripts were individually coded using open coding until saturation was reached. The lead investigator then applied these codes to the remaining transcripts. Following the open-coding process, the lead investigator reviewed the results and formed conceptual categories based on emerging variables. This process was repeated until core themes emerged.

Biases

A personal log was kept by all four coders in order to explore biases and perceptions of the subject matter. This researcher kept a personal log with impressions of each of the participants, including observations and interpretations of appearance, affect, and body language. The additional coders kept logs while reading the transcripts in order to document their own impressions and interpretations of the data. The logs were compared during the coding process in order to explore any biases or perceptions of the participants and subject matter. This process was completed in order to warrant reliability and validity of the data.

This researcher has a background and training in forensic psychology and counseling, which brings this viewpoint to the research. She has extensive training in mental-health and substance abuse treatment through master's- and doctoral-level coursework and professional clinical work. She has worked with the ex-offender population in outpatient mental-health clinics and has been able to witness their many struggles during the course of the reentry process and obtaining treatment. The idea for this dissertation topic arose from her experiences with working with this population. Through experiencing the barriers that this population faces during the reentry process and the positive effects of positive support and treatment engagement, advocacy for this population has become a professional and personal goal.

The three additional coders have also worked with this population and have training in counseling, which bring this viewpoint to the research. One coder expressed working with both of the participant groups while working in a probation office in the Philadelphia area. This coder was currently working with the probation office and had an understanding of the reentry process for this population. The second coder expressed working with the ex-offender population while working as a counselor. She also expressed that she understood the reentry process in the Philadelphia area and described several that she was aware of. The third coder expressed having minimal experience working with this population or understanding the reentry process. However, she does have training and knowledge in counseling and completed research on the topic of stigmatization in her Master's program.

During the coding process, the coders found that their different backgrounds impacted their interpretation of their perceptions of the interviewed participants'

transcripts. This researcher approached the coding from the role of direct observer of the participant, while the other three coders had no knowledge of the participant's profession or of his demeanor, body language, or affect during the interviews. Despite these differences, all three coders agreed on the codes produced through data analysis.

Chapter 3: Results

Emerging Themes

During the analysis of the narratives, core themes emerged. Three themes emerged from the professional narratives, and one theme emerged from the ex-offenders. The higher number of themes from the professional narratives may be the result of the professionals having more to say during the narratives in comparison to the ex-offenders. The themes that emerged entailed perceived stigma by professionals, professionals' negative views of reentry programs and the ex-offender population, barriers to treatment and successful reentry, and the importance of a positive support system and destigmatizing the reentry process.

The first theme that will be discussed is perceived stigma by professionals, which is defined as their perceptions of how ex-offenders experience stigma and shame and how it impacts the ex-offenders' use of reentry programs and/or mental-health/substance abuse treatment facilities. The professionals discussed examples of stigma more than the ex-offenders did. The ex-offenders interviewed in the study did not appear to care about what others thought and mainly focused on themselves throughout the reentry process. They expressed making the decisions in order to better themselves and did not express concepts of personal or public stigmatization. However, professionals believed that personal and public stigma play a huge role in the use of reentry programs and treatment both during incarceration and post release. The majority of professionals expressed their belief that ex-offenders do not engage in services during incarceration because they are worried about how the other inmates will look at and think of them. The

professionals stated that they believe this population experiences many feelings of shame and embarrassment that impact their getting the help that they need during and after incarceration.

Narrative examples of personal stigma that professionals perceived would impact use of services were as follows: *“Pride stops them from using services,” “Feelings of shame and embarrassment,” “Ashamed of who they are,” “They don’t use the services due to looking like they have a weakness,” “No one wants to admit they are different,”* and *“Wish they were like everyone else around them.”*

Narrative examples of public stigma that professionals perceived impacted use of services were as follows: *“They feel that others are going to make fun of them or look down on them for using the services,” “They don’t want others to look down on them for things that they have done,” “They worry about what everyone else thinks of them going to the courses,” “There is a lot of judgment,” “Most places don’t want to help ex-offenders,” “Mental health and drug history can be seen as a weakness,” “Afraid of what others are going to say to them,” “They may be treated unfairly by others because they have a criminal record,”* and *“They have a record and probably have a hard time finding a job with a criminal record.”*

The second theme that emerged was professionals’ negative views of reentry programs and ex-offenders. This theme is defined as their perceptions of the nature of reentry programs and ex-offenders’ lack of participation in the programs. The professionals expressed in-depth negativity toward the ex-offender population. They appeared to display a public stigma toward them, as well as toward the reentry programs that are assisting them with reintegrating back into the community. The professionals did

not feel that the programs were helpful for ex-offenders and/or that ex-offenders were not willing to use them. The professionals expressed concerns about laziness and the ex-offenders using the services only to get what they need and not for actual treatment. Professionals appeared to believe that even with the use of reentry programs recidivism would continue to be a problem. The narratives were riddled with many judgmental statements regarding the ex-offender population.

Narrative examples of professionals' negative views of reentry programs and ex-offenders include the following: *"Reentry programs seemed robotic, and they [staff] didn't seem interested or show empathy," "They are not getting what they need from these services to stay out on the street and not back behind bars," "I think it's a failure to admit they have a problem," "They are not ready for treatment," "I hear them say that treatment does not help or that it was a waste of their time," "If you put a bunch of drug addicts together, chances are they are going to talk about their experiences and end up going back to using," "Can't have the same kind of people that struggle with addiction in the same environment," "Their own stupidity gets in the way," and "If they do go it's only because they went for treatment before getting locked up and need meds."*

The third theme that emerged focused on barriers to treatment and engagement in reentry programs as perceived by professionals. This theme is defined as obstacles that prohibit or make treatment participation difficult for ex-offenders. The professionals were able to express that some of the reasons that this population does not get the help that they need during reintegration is because of multiple barriers that they face. They are aware that these barriers exist and expressed that knowledge of them may increase participation in reentry programs and mental-health and/or substance abuse

treatment. The barriers discussed by professionals appeared to be at multiple levels, including transportation, lack of insurance, lack of knowledge of programs, lack of self-motivation, and scheduling concerns. They expressed their belief that these barriers cause ex-offenders not to follow through with treatment. Some also expressed that in some cases the family can be a barrier. They stated that the families lack knowledge of how treatment or reentry programs work and thus want them to work immediately. Professionals believe this interaction with loved one cause the ex-offenders to get frustrated and give up on the process. Ex-offenders did mention some of these barriers in their narratives, including lack of insurance, lack of knowledge of services, and scheduling conflicts; however ,they did not explicitly state them as barriers. They mentioned them as resources that they needed help achieving and as reasons for engaging in services through the reentry programs. Many of the ex-offenders expressed that the reentry programs helped them obtain insurance for treatment and set up intake appointments for mental-health and/or substance abuse appointments.

Narrative examples of barriers to treatment and engagement in reentry programs as perceived by professionals include the following: *“Not having insurance makes it difficult for them,” “Many of these treatment places have a long waiting list,” “Taking the bus can make it difficult to get to appointments,” “Geographic locations,” “They are just lazy,” “Their own stupidity not to use services,” “Lack of advertising for reentry programs and treatment facilities,” “No advertisement for these kinds of services,”* and *“Scheduling conflicts between counseling with work schedule.”*

Additionally, a subtheme emerged: Mental-health treatment was stigmatized and considered its own barrier compared to drug and alcohol treatment. Throughout the

narratives of professionals and ex-offenders, mental-health treatment was discussed in a negative way in comparison to drug and alcohol treatment. Drug and alcohol treatment was perceived as more accepted and normalized. Overall, more reasons were offered for why ex-offenders did not obtain mental-health treatment that they needed than for not seeking drug and alcohol treatment. Some of the reasons that were expressed were feeling uncomfortable talking to a stranger about their thoughts, mental-health problems being more personal than drug and alcohol use, and thinking that counseling was a waste of time and talking to someone would not help them in any way.

Narrative examples of mental-health treatment being stigmatized include the following: *“Waiting lists are more applicable to mental health than substance abuse treatment centers,” “I’m not sure families knew about mental health stuff until the guys would open up to them about it,” “Some people have families that feel mental health is a weakness,” “Mental health isn’t usually a priority,” “Depending on religion, mental health is not something that is talked about,” “Why would I speak with a stranger about my personal problems?,” “My mental health is more of a touchy subject,” “Mental health counseling is not going to help me,” “They only go to counseling to get meds,”* and *“If people get counseling, they are considered crazy.”*

The fourth theme that emerged was a positive support system and destigmatizing the reentry process and treatment utilization. This theme is defined as how ex-offenders viewed perceived support from family, friends, and professionals as having a positive impact on the participation in reentry programs and motivation toward engagement in mental-health and/or drug and alcohol treatment pre and post release. The ex-offenders expressed that the support of those around them both pre and post release had a major

impact on their engagement in services. They expressed that by engaging in services during incarceration they were able to link with services easier post release. They were also aware of the types of services available and understood how treatment worked. They expressed that they were encouraged by their families to get the treatment and reentry services they needed. The involvement of those around them appeared to increase the likelihood of using both services during incarceration and during the reentry process. Those who did not have family involvement expressed that the encouragement and support from probation officers, reentry staff members, and counselors increased adherence to the programs. They stated that they did not feel judged and that this lack of judgment encouraged them to continue through the reentry process and get the help they needed. Some of the ex-offenders even encouraged and supported peers' use of reentry programs and mental-health and/or drug abuse treatment facilities.

Narrative examples of positive support system and destigmatizing the reentry process and treatment use include the following: *“People that are around me in jail and the ones that came to visit me were really supportive,” “My family was grateful that the program was here to get me back on track and keep me from relapsing,” “A buddy of mine helped me get into a reentry program,” “Probation told me about the reentry program,” “My family is proud of me for using the services,” “My family is supportive of me getting the help that I need,” “Family came to a couple sessions and are proud,” “The reentry program really helped me out, and I thought it was great,” “They didn’t judge me and helped me find a treatment program,” “They didn’t turn their back on me,” “I think it’s cool that they cared enough to take the time to refer me to services,”*

and “*The reentry people actually cared and want us to stay clean and make progress in the community.*”

Research Questions’ Findings

In this section, the four research questions that were asked for the purpose of this study will be further examined.

Question 1: What are ex-offenders’ views and/or thoughts regarding reentry programs?

Overall, ex-offenders apparently felt that the reentry programs were very helpful with their reentry into the community. Many believed that if not for the assistance and guidance of these programs, they would be either back to old habits or back in jail. They thought that the staff was helpful and did not have anything negative to express during their interviews. However, professionals did not have the same view of reentry programs and felt that the programs needed to be better at providing services in order to reduce recidivism rates.

Question 2: How do services received in prison or jail impact decision-making about entering into reentry programs?

The individuals who engaged in the services during incarceration apparently were more likely and willing to use reentry programs. They expressed that they were informed about the reentry programs from their counselors while in jail and were encouraged to use them in order to get continued mental-health and/or substance abuse treatment post release. Engaging in services in jail seems to have an impact on decision-making about entering into reentry programs, as well as treatment programs.

Question 3: What influences ex-offenders’ choices to seek mental-health and/or substance abuse treatment services as part of their reentry program?

The overall theme that influenced ex-offenders to get mental-health and/or substance abuse treatment services as part of their reentry process was a positive support system and lack of stigmatization. They expressed that their families supported them during the process and encouraged them to get the treatment they needed. Many of them expressed that the staff in the reentry programs also encouraged them to get the help that they needed for their mental-health and/or substance abuse concerns. They stated the staff did not express judgment and helped them set up necessary appointments. Many felt that without this continued feeling of support, they may not have decided to get treatment.

Question 4: What role does perceived public and self-stigma play in seeking services following discharge from jail?

The ex-offenders did not explicitly express anything regarding the role of public or self-stigma in seeking services during reentry. They focused more on the positive support that they received from others during this process. However, the professionals who were interviewed perceived that both public and self-stigma play a major role in the use of services during the reentry process. They felt that being aware of the role of public and self-stigma was important to understanding why ex-offenders do not seek and use services post release and why recidivism rates are high.

Chapter 4: Discussion

The current study explored individual perspectives of professionals and ex-offenders regarding reentry programs and the impact that public and internal stigmatization have on treatment decision-making. It also looked at topics of access and adherence to mental-health and/or substance abuse treatment from the individual perspectives of ex-offenders and professionals. The outcomes of the study showed several themes. The themes included (a) understanding the barriers faced post release and their impact on access and adherence to mental-health and/or substance abuse treatment, (b) a positive experience with mental-health and/or substance abuse treatment while incarcerated will increase likelihood of accessing and adhering to treatment post release; (c) having a positive support system, including family, friends, and professionals, during the reentry process reduces recidivism rates and increases treatment adherence; and (d) an overall better understanding of the impact that stigmatization has on the treatment decision-making process.

Similar to the findings in previous studies, this study found that the barriers faced during reentry can have an impact on adherence and access to mental-health and/or substance abuse treatment (SAMHSA, 1999). The professionals and ex-offenders were able to identify barriers, including transportation difficulties, lack of insurance, and lack of knowledge of services and how to access them. Understanding these barriers and ways to address them will increase the likelihood of access and adherence to mental-health and/or substance abuse treatment. Additionally, ex-offenders expressed that the positive experiences with treatment while incarcerated also increased the likelihood of engaging in treatment post release. Research has shown that this increased likelihood of

engaging in treatment post release due to positive experiences with treatment during incarceration is particularly important for drug and alcohol treatment (Department of Criminal Justice, 2001). These findings implicate the importance of providing and encouraging active treatment during incarceration.

Another factor found to be highly important in increasing access and adherence to mental-health and/or substance abuse treatment was the support from family, friends, and professionals, both pre and post release. Professionals and ex-offenders expressed that without the needed support, ex-offenders would have been unlikely to engage in services and the chances for recidivism would have been higher. These findings are consistent with other research findings and further exemplify the need for a positive support system for this population during the reentry process (Malik-Kane & Visher, 2008). Also, in contrast to previous research, the ex-offenders who were interviewed did not discuss concepts of stigma (Livingston et al., 2011; Winnick & Bodkin, 2008). The ex-offenders who were interviewed might not have felt comfortable speaking about stigma and chose not to reveal interactions that they may have encountered pre and post release. However, findings revealed professionals who were interviewed expressed a higher level of concern with stigma and how it played a role in treatment decision-making for ex-offenders. These findings can provide insight regarding the difference in views of stigma between ex-offenders and professionals working with this population, particularly police officers, and can provide opportunities for educational trainings on the topic.

The professionals also had an overall negative view of ex-offenders and the reentry process and expressed concerns of recidivism and ex-offenders' lack of motivation toward treatment. Research findings have found that public stigma does have

an impact on successful reentry and treatment adherence (Corrigan & Watson, 2002; Lebel, 2011; Livingston et al., 2011; Van Olphen et al., 2009). Additionally, findings revealed the inclination of individuals to speak more openly about their substance abuse treatment and experiences in comparison to their mental-health treatment. Both implicitly and explicitly, substance abuse treatment was more widely accepted and normalized compared to mental-health treatment by the ex-offenders, families, friends, and professionals. Overall, these findings exemplify the need for increased advocacy for this particular population and additional educational trainings for professionals involved in their reentry process.

The process of collecting data revealed that a major barrier during the reentry process is finding a comprehensive reentry program. Although reentry coordinators can be found through the county offices, the number of specialized reentry programs for these individuals is not sufficient. Many of the programs that were contacted for this study offered assistance to ex-offenders during their reentry process, but the programs were not comprehensive in nature. Comprehensive programs assist the population through the entire process, from discharge to access to resources and finally to follow-up services. The programs encountered during this study would point the individuals in the right direction or give them information but would not actually assist them throughout the entire reentry process. In order to be effective, programs need to be established that focus on the individual's needs from the beginning to the end of the reentry process. Additionally, the reentry programs that are established in the community are not being advertised sufficiently. Until individuals are aware that these programs are available, the concept of the "revolving door" is going to continue. Ex-offenders who are being

released need to know that these programs are available to assist them through this process. Based on these findings, more awareness and advocacy for these programs are necessary. Professionals who work with this population need to be aware of what resources are out there that can make the reentry process easier. More knowledge is needed about the quality of these programs and what is actually being provided. Barriers to reentry exist for this population, and without establishing effective ways for overcoming them, recidivism rates are going to continue to increase.

Overall, if an effective reentry process is implemented, ex-offenders will have a higher likelihood of successfully transitioning into the community and will more likely access and adhere to mental-health and/or substance abuse treatments based on previous research findings (Department of Criminal Justice, 2001; Draine et al., 2005; Lurigio et al., 2004; Wikoff et al., 2012). An effective reentry program is thought to be preceded by the individual having received caring and appropriate treatment during incarceration (Department of Criminal Justice, 2001). Additionally, such a program needs to address the barriers to post-release treatment on an individual basis and provide advocacy for this population. Findings from this study will assist mental-health and criminal-justice professionals to better understand the needs of this population, as well as allow community organizations to assist with collaborating in the reentry process and treatment needs.

Suggestions for Future Work

Further investigations need to be conducted to understand different facets of the reentry process and treatment decision-making processes among this population. More research should focus on the topic of the effect of gender on this process. Based on a

review of literature, gender can impact a person's movement through the reentry process and perceived stigmatization. Additionally, conducted studies can also explore how race/ethnicity can impact the individual's treatment decision-making process and perceptions of stigmatization during the reentry process. A future study can use qualitative methodology and compare gender and/or ethnic differences on the topics of reentry process, mental-health and/or substance abuse treatment, and perceived stigmatization. This study will allow professionals in the field to formulate an effective reentry plan based on individual needs. Future research can also be conducted in separate geographic areas to broaden the understanding of reentry program perspectives across different locations. More quantitative research is needed that allows for at least some randomization that can compare and contrast effective reentry program components and study moderators, such as gender and geographic location, or mediators, such as stigma, on reentry outcomes. Such studies could help explain the entire process based on environmental and personal differences among this population.

An additional area that has had minimal research to date is an individual's religious and/or spiritual beliefs. A study could examine the possible impact that different religions and/or religious beliefs may have on treatment decision-making and the reentry process for ex-offenders. Another research study that may shed light on the reentry process and its differences among individuals is one that compares and contrasts the differences between adult ex-offenders and juvenile offenders. This study will formulate ideas regarding the different and specific needs of these populations during this process and will also have an impact on the revolving-door concept, thereby allowing providers to understand juvenile offenders' needs and help reduce recidivism

rates. Additional studies should also be conducted with various professionals who work with this population to better understand their knowledge and views regarding the reentry process and ways that professionals could assist with a smoother transition during the reentry process. Lastly, a quantitative study can be conducted to compare and contrast the needs of those released from prisons in comparison to jails to see if the length of sentencing impacts treatment decision-making and perceived stigmatization.

Limitations of the Current Study

The main problem with the current study is the small number of participants sampled which reduces the ability of the study to generalize to other populations or geographic areas. Another concern is that the sample interviewed had no past incarcerations. Individuals with a higher number of incarcerations may have different treatment and reentry needs. This study focused on interviews received from and focused on ex-offenders over the age of 18 years and will not be generalizable to the juvenile population. The juvenile population has different barriers to smoother transitioning and access to mental-health and/or substance abuse needs that need to be furthered assessed. Another limitation is that this study is focused on individuals who were recently released from jails. These individuals most likely had shorter sentences and less violent criminal histories compared to those of ex-offenders who were released from prisons, possibly impacting perceived stigmatization. Another limitation is that all the professionals interviewed were from the same occupation, reducing generalization to other professions. Additionally, the researcher had minimal experience conducting qualitative research and learned how to conduct this type of research throughout this

process. The minimal experience with this form of research may have had an impact on the approach to the interviews and coding analysis.

In conclusion, this study established the importance of implementing an effective reentry plan for ex-offenders prior to discharge in order to increase successful transitioning back into the community, as well as to increase the likelihood of their accessing and adhering to mental-health and/or substance abuse treatments. Also, findings showed that important factors for effective reentry included engagement in appropriate treatment during incarceration and having a positive support system throughout the reentry process. Additionally, reentry programs need to address the barriers to post-release treatment on an individual basis. Furthermore, the perceived stigma and self-stigma experienced by ex-offenders, an area with limited findings for the population in the current study, suggest that further exploration of this topic is needed. Findings from this study will assist mental-health, substance abuse, and criminal-justice professionals, as well as community providers, with a better understanding of the reentry process, needs of the individuals during this process, and factors that impact overall treatment decision-making.

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COMMUNITY RE-ENTRY

10. What is your current living situation?

- Own Rent Homeless (street/car/empty building/etc.)
- Shelter Group home Transitional housing Assisted living
- Living with someone else (specify): _____
- Other (specify): _____

11. What was your living situation prior to incarceration?

- Own Rent Homeless (street/car/empty building/etc.)
- Shelter Group home Transitional housing Assisted living
- Living with someone else (specify): _____
- Other (specify): _____

12. Have you had any previous mental health and/or substance treatment?

- Yes (please describe) _____
- No

Appendix B

Interview Questions for ex-offenders

1. Tell me what services were available for you in jail?
 - a. Tell me about your thoughts and feelings about these services?
 - b. What were the thoughts and feelings of others regarding your use of these services?
2. What are your thoughts about the re-entry program you are participating in?
 - a. How did you become involved with this program?
 - b. What have your experiences been like so far?
 - c. What do you find helpful in this program?
 - d. What do you find not helpful?
 - e. How do you feel about using these services?
 - f. How do you think your family, friends, associates felt about you using these services?
3. Did you choose to go to mental health and/or substance abuse treatment as part of your re-entry process?
4. If you did attend mental and/or substance abuse treatment what was this experiences like for you?
 - a. How has this experience been for you so far?
 - b. What were the benefits of attending (for those that did)?
5. If you did not choose to attend mental health and/or substance abuse treatment what factors played a role in your decision?
 - a. What were the benefits of not attending (for those that did not attend MH and/or SA)?
 - b. What would have made you more likely to attend treatment?
6. Do your family, friends, and associates know you are in a mental health/substance abuse program?
 - a. What do those who know about your mental health/substance use think about it and you?
 - b. How do you think the people in your life that do NOT know about your mental health and/or substance use would think about you if they knew about them?
 - i. What are some of the reasons you have not told them?
7. Is there anything I left out or anything else you want to tell me?

Appendix C

Demographic Questionnaire for Professionals

Client ID # _____ Survey date _____

Please enter the following information

1. Occupation title: _____
2. Number of years spent working with ex-offender population: _____years

Gender _____

Appendix D

Interview questions for those who have professional contact with ex-offenders

1. Tell me what services are available to male offenders in jail?
 - a. Tell me about your thoughts and feelings about these services?
 - b. Do you feel that the thoughts and feelings of others impacted use of these services by the offenders?

2. What are your thoughts about re-entry services available to male ex-offenders?
 - a. How do they become involved with the program?
 - b. What have their experiences been like so far?
 - c. What do they find helpful in the program?
 - d. What do they find not helpful?
 - e. How do they feel about using these services?
 - f. How do you think their family, friends, associates felt about them using these services?

3. Did they choose to go to mental health and/or substance abuse treatment as part of their re-entry process?

4. If they did attend mental and/or substance abuse treatment what was their experience like?
 - a. What were the benefits of attending (for those that did)?

5. If they did not choose to attend mental health and/or substance abuse treatment what factors played a role in their decision?
 - a. What were the benefits of not attending (for those that did not attend MH and/or SA)?
 - b. What would have made them more likely to attend treatment?

6. Do their family, friends, and associates know they are in a mental health/substance abuse program?
 - a. What do those who know about their mental health/substance use think about it and them?
 - b. How do you think the people in their life that do NOT know about their mental health and/or substance use would think about them if they knew about them?
 - aa. What are some of the reasons they have not told them?

7. Is there anything I left out or anything else you want to tell me?