

8-13-2017

Critical Keys to Successful Offender Reentry: Getting a Handle on Substance Abuse and Mental Health Problems

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Recommended APA Citation

Gunnison, E., & Helfgott, J. B. (2017). Critical Keys to Successful Offender Reentry: Getting a Handle on Substance Abuse and Mental Health Problems. *The Qualitative Report*, 22(8), 2152-2172. <https://doi.org/10.46743/2160-3715/2017.3260>

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Abstract

Over the past several decades, all facets of institutional and community corrections have been growing. This growth has resulted in increased numbers of ex-offenders reentering society. While research has emerged on reentry, much of the research has focused on examining reentry failure as opposed to reentry success. Interviews of 40 ex-offenders and community corrections officers were conducted in Washington State to pinpoint what is needed to assist ex-offenders as they reenter society—particularly as it relates to substance abuse and mental health treatment. Results from interviews revealed that ex-offenders need assistance to address substance abuse and mental health issues while incarcerated and in the community. Interview results indicated that lack of access to treatment providers or quality treatment to assist ex-offenders are key hindrances identified by ex-offenders in the reentry process. Policy implications of the results are provided.

Keywords

Reentry, Ex-Offenders, Success, Community Corrections Officers, Substance Abuse, Mental Health, Narrative Analysis

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Critical Keys to Successful Offender Reentry: Getting a Handle on Substance Abuse and Mental Health Problems

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Over the past several decades, all facets of institutional and community corrections have been growing. This growth has resulted in increased numbers of ex-offenders reentering society. While research has emerged on reentry, much of the research has focused on examining reentry failure as opposed to reentry success. Interviews of 40 ex-offenders and community corrections officers were conducted in Washington State to pinpoint what is needed to assist ex-offenders as they reenter society—particularly as it relates to substance abuse and mental health treatment. Results from interviews revealed that ex-offenders need assistance to address substance abuse and mental health issues while incarcerated and in the community. Interview results indicated that lack of access to treatment providers or quality treatment to assist ex-offenders are key hindrances identified by ex-offenders in the reentry process. Policy implications of the results are provided. Keywords: Reentry, Ex-Offenders, Success, Community Corrections Officers, Substance Abuse, Mental Health, Narrative Analysis

Research on offender reentry over the past thirty years has demonstrated that offenders' ability to reintegrate successfully is hindered by numerous obstacles such as difficulty in obtaining employment, acquiring housing, and being admitted to higher education (Allender, 2004; Cowan & Fionda, 1994; Delgado, 2012; Gunnison & Helfgott, 2013; Harlow, 2003; Harris & Keller, 2005; Hunt, Bowers, & Miller, 1973; James, 2015; Nagin & Waldfoegel, 1998; Paylor, 1995; Rodriguez & Brown, 2003; Starr, 2002; Whelan, 1973) along with serious social and medical problems (Petersilia, 2003). Newly released offenders encounter stigmatization (Bahn & Davis, 1991; Funk, 2004; Steffensmeier & Kramer, 1980; Tewksbury, 2005), lose social standing in their communities (Chiricos, Jackson, & Waldo, 1972), and are in need of social support (Cullen, 1994; La Vigne, Visher, & Castro, 2004; Lurigio, 1996) and substance abuse and mental health treatment (Gunnison & Helfgott, 2013; James, 2015; Mallik-Kane & Visher, 2008; Petersilia, 2003). Substance abuse, in particular, not only plays a pivotal role in the onset of criminal involvement for many offenders, it also poses a significant hurdle to reentry success for ex-offenders—especially since offenders suffer from substance abuse or dependence at higher rates than those in the general U.S. population (Solomon, Osborne, LoBuglio, Mellow, & Mukamal, 2008; Travis, Solomon, & Waul, 2001; Wodahl, 2006). Travis and colleagues (2001) estimate that up to 75% of all ex-offenders have a history of substance abuse or addiction. It is also estimated that two-thirds of individuals in the criminal justice system have a substance abuse problem and are in need of treatment services (Taxman, Young, Wiersema, Rhodes, & Mitchell 2007).

It is clear that for ex-offenders reentering society from jails or prisons or who are serving sentences, such as probation in the community, need assistance beyond having their basic needs met (i.e., housing, food, and employment). One critical key to their successful reentry is obtaining substance abuse treatment. Unfortunately, many ex-offenders suffer from co-occurring problems such as mental illness which further stymies their ability to successfully reintegrate back into society. Persons with mental illness are overrepresented in jails and prisons. A 2006 Bureau of Justice Report on mental health problems of prison and jail inmates

found that an estimated 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates had mental health problems (James & Glaze, 2006). It is estimated that of those incarcerated 6–8% have a serious mental illness in state prisons, 7.2% suffer from serious mental illness in jails, and many more that have had contact with the criminal justice system but were not incarcerated suffer from mental health problems (National Alliance on Mental Illness, 2008). Other researchers have found that as high as 16% to 30% of offenders have serious mental illnesses such as schizophrenia, bipolar disorder, delusional disorder, and a range of other disorders (Schug & Fridella, 2015). Davis and Pacchiana (2004) report that the prevalence of schizophrenia and bipolar disorder are about one to five times greater in the prison population than the general population. In addition, many individuals with mental illness are involved in behavioral crisis events in the community before and after periods of incarceration. These individuals are known as “high utilizers,” “frequent-fliers,” or “mental health frequent presenters” who are mentally ill or disordered, have multiple needs, and are frequent utilizers of emergency services (Andrews & Baldry, 2013) who are well-known to both the law enforcement and the mental health communities. These individuals exhibit persistent offense behaviors that consume a disproportionate amount of police response time over the long term (Reuland, Schwarzfeld & Draper, 2009). There is widespread evidence that those with mental conditions are overrepresented in their interactions with the criminal justice system at the front-end of the criminal justice process in interactions with police and in the community as well as in institutional and community corrections and that this occurs not just in the United States but also internationally (Baldry & Douse, 2013). Some groups such as Akron, OH’s Crisis Intervention Team (CIT) Outreach team and Pasadena, CA’s Homeless Outreach Psychiatric Evaluation (H.O.P.E.) team have focused their efforts on “high utilizers” to curb law enforcement contacts (Criminal Justice/Mental Health Consensus Project, 2011). For example, these groups periodically check on “high utilizers” by engaging clients in “knocks and talks,” and during this welfare checks, the caseworkers make sure that their clients are obtaining the services they need. Both teams have found that such an approach can result in a reduction in law enforcement incident calls regarding these individuals (Criminal Justice/Mental Health Consensus Project, 2011; Reuland, Draper & Norton, 2010). Many ex-offenders are part of this group of high criminal justice system utilizers in need of mental health treatment, often in tandem with substance abuse treatment, in order to be able to successfully reenter society.

Previous research has emerged regarding ex-offender reentry challenges from the perspective of ex-offenders themselves (see Cobbina, 2009; Dodge & Pogrebin, 2001; Earle, Bradigan, & Morgenbesser, 2001; Martin, 2008; Maruna, 2001; Oh & Umemoto, 2005; Oliver & Hairston, 2008; Richie, 2001). The use of qualitative methodologies to explore ex-offender reentry by our predecessors has provided a strong foundation for understanding ex-offender reentry. Yet, some gaps still remain—specifically with respect to pinpointing the role of substance abuse and mental health treatment in successful ex-offender reentry from the perspective of both ex-offenders and community corrections officers (CCO). Latessa and Smith (2011) suggest that CCOs understand the needs of ex-offenders and play a vital role in assisting ex-offenders in their transition back into society. If this is indeed the case, then obtaining the views of CCOs in addition to those of offenders on these issues is critical. Thus, this research closes the gap in the literature by examining the role of substance abuse and mental health treatment from the perspectives of ex-offenders who have successfully reintegrated back into society and CCOs who work to reintegrate offenders back into society each day. Further, this research examines the role that substance and mental health treatment play in successful ex-offender reentry to better inform policymakers as to how these factors contribute to successful reintegration.

Literature Review

In 2013, just under 7 million offenders were serving under some form of correctional supervision (i.e., prison, jail, probation, and parole; Glaze & Kaeble, 2014). Of that total, approximately 1.2 million offenders were serving sentences in prison. Every year in the United States approximately 700,000 men and women leave federal and state prisons and return to society (Sabol, Minton, & Harrison, 2007). Thus, each day offenders are attempting to successfully reintegrate back into their communities. However, successful reentry is an evasive goal for many. In the past decade, researchers have begun to explore the needs and challenges that offenders face during reentry and what factors may pave the way for successful reentry (Gunnison & Helfgott, 2013; Petersilia, 2003). It has become apparently clear that critical factors to successful reentry include access to quality substance abuse and mental health treatment programs, however, access to such treatment is often limited (Lynch & Sabol, 2001; Taxman, 2004).

Substance Abuse

Drug addiction is a pervasive problem for a sizeable majority of offenders—whether they are incarcerated or are serving their sentences in the community (Chandler, Fletcher, & Volkow, 2009; SAMHSA, 2005). Given that addiction is a chronic brain disease with genetic and biological underpinnings, most addicted individuals require treatment that is long lasting and meaningful if they are to overcome it (Chandler et al., 2009; NIDA, 2012). The link between substance abuse treatment and successful offender reentry outcomes has been well established in the literature. Research has revealed that ex-offenders who participate in treatment while incarcerated and in community-based substance abuse programs after release have lower levels of substance use and moderately lower rates of recidivism (Anglin, Prendergast, Farabee, & Cartier, 2002; James, 2015; Inciardi, Martin, & Butzun, 2004; Jannetta, Dodd, & Elderbroom, 2011; McDonald & Arlinghaus, 2014; Miller & Miller, 2010; Visher & Courtney, 2007; Wexler, DeLeon, Thomas, Kressel, & Peters, 1999; Wright, Zhang, Farrabee, & Braatz, 2014; Zhang, Roberts, & Callanan, 2006). Zhang and colleagues (2006), who examined the Preventing Parolee Crime Program in California—a program that provided a wide range of services to parolees including substance abuse assistance—found this program modestly reduced recidivism and parole absconding. More recently, McDonald and Arlinghaus (2014), in an examination of 108 female offenders who participated in the Northern Kentucky Female Offender Project which targets women with substance abuse histories, found that treatment did reduce recidivism rates for these participants—specifically 74% of the women did not commit a new crime.

Further complicating reentry for jail inmates is their relatively low levels of participation in drug/alcohol treatment programs while incarcerated (Solomon et al., 2008). Part of this problem may stem from the fact that “less than one-fifth of convicted jail inmates who meet the criteria for abuse or dependence receive formal treatment or other programs after admission to jail” (Crayton, Ressler, Mukamal, Jannetta, & Warwick, 2010, p. 21). The other part of this problem is that approximately two-thirds of jails do not offer formal treatment (SAMHSA, 2005). Much of the treatment in jails offer self-help programs for drug addicted offenders and one-third of jails offer detoxification (SAMHSA, 2005). The lack of access to formal substance abuse programs for jail inmates may also stem from cuts to state or county correctional budgets (Lynch & Sabol, 2001; Scott-Hayward, 2009). For fortunate offenders who are able to access treatment while incarcerated, the programs were of poor quality or the offenders may not have seized the chance to engage in substance abuse programming while incarcerated. In a qualitative study of female ex-offenders, Richie (2001) reports that one

woman found it difficult to get clean and sober while incarcerated as programs would get cancelled, officers would forget to call her out of her housing unit for programs, or the programs lacked substance in helping her address her deep issues. As soon as the woman left prison she went back to abusing drugs and reflected on her experience in jail, "I'm an addict...I really need help, but I didn't get it in jail...Now I'm back where I started" (Richie, 2001, p. 372).

Ex-offenders with substance abuse histories (the majority of the ex-offender population) making the transition from incarceration to the community are in the precarious position of having to manage extraordinary stressors (i.e., finding housing, securing employment, reuniting with family) and stigma without engaging in old habits of substance use and abuse as a way to manage those stressors and other problems they may face (Chandler et al., 2009; Taxman, 2004). A recent qualitative study of ex-offenders conducted by Phillips and Lindsay (2011, p. 145) further supports the idea that many ex-offenders facing the stresses of reentry are reverting to drug and alcohol use. In their study, one subject reported, "I don't cope. I did when I was younger, but once I found a drug, I just run to it. I dealt with so much at a young age, so it was easier to avoid things and get temporary relief from drugs. Every time I have a problem, it solves it. I want something to take over my guilt and shame, but it gets worse." Another subject simply reported, "Every problem I've ever had, I've drowned in drugs and alcohol" (Phillips & Lindsay, 2011, p. 146). Thus, the temptation for ex-offenders to alleviate stress with drugs and/or alcohol during reentry is high.

Further complicating successful offender outcomes is that not all ex-offenders have access to community-based treatment programs during reentry (Crayton et al., 2010; Thompson, 2004). Crayton and colleagues (2010, p. 21) explain that "lack of insurance, conviction-based bans on receiving public assistance, or the lack of available treatment can create substantial barriers to post-release substance abuse treatment." The quality of the substance abuse treatment program may also contribute to whether the ex-offender can have successful outcomes post-release. Richie (2001, p. 327) recounts one woman's struggles in attending treatment and being able to focus on her recovery which she attributed to men who harassed her in the treatment group. The subject reported "I really tried to go to treatment. But I couldn't stand how they treated me. Mostly it was the men in the group who always want to get some [have sex]. They offer nicely at first, then they teased me, they just stared at me whenever I talked.... So, I stopped going altogether." For this subject, her gender role in this program and the environment of the program were not conducive to support her sobriety, resulting in her having to recover from her substance abuse problems on her own.

Without access to formal or quality treatment, whether by circumstance or choice, ex-offenders may come to rely on their community corrections officer for assistance (Thompson, 2004). The community corrections officer (CCO) may very well be the only prosocial individual in the life of the ex-offender, and thus, the ex-offender really must rely on the CCO for support and guidance. Unfortunately, CCOs generally have a large client caseload and are not trained treatment providers inhibiting their ability to navigate ex-offenders through the pathway of recovery from addiction or abstinence from drug and alcohol consumption. With community-based substance abuse programs being unreachable or unattainable for many ex-offenders, many researchers have found that these offenders will continue consuming drugs and alcohol upon release (La Vigne, Visher, & Castro, 2004).

Since drug addiction is indeed a struggle for some ex-offenders, substance abuse treatment is a critical need for ex-offenders that must be addressed if they are to be expected to successfully reenter society and overcome basic co-occurring challenges such as obtaining housing and employment (McKean & Raphael, 2002). Without suitable housing, ex-offenders must resort to being homeless or residing in an environment (i.e., a high crime community) that undermines their likelihood of successful rehabilitation and reintegration (Bradley, Oliver, Richardson, & Slayter, 2001; Clear, 2007; Hamilton, Kigerl, & Hays, 2013; Kirk, 2009, 2012;

Kubrin & Stewart, 2006; Rodriguez & Brown, 2003). Housing is particularly critical for reentry success for those with substance abuse and mental health histories (Fontaine & Biess, 2012).

Many ex-offenders with drug addictions are also in need of mental health support (Lurigio, 1996; Jaffee, Du, Huang, & Hser, 2012; McDonald & Arlinghaus, 2014; Sung, Mellow, & Mahoney, 2010; White, Goldkamp, & Campbell, 2006). The stress of successfully reintegrating into society is high, and some ex-offenders resort to drastic measures beyond alcohol and drug use such as suicide in response to the stress and strain that they are experiencing during this tumultuous time (Biles, Harding, & Walker, 1999; Binswanger et al., 2007; Pratt, Appleby, Piper, Webb, & Shaw, 2010).

Mental Health

As noted earlier, mental health issues are clearly an overwhelming challenge for many ex-offenders attempting to reenter society, and Travis et al. (2001) report that approximately 16% of all ex-offenders have a diagnosable mental disorder. Previous researchers have estimated that while 10 percent of all males in prison suffer from mental illness, 19 percent of women in prison are mentally ill (Peters & Hills, 1993). More recently, James and Glaze (2006) report that over 1.2 million inmates in prisons and jails, not including offenders on probation or parole, suffered from mental health problems. Researchers have found that though an overwhelming number of people incarcerated with psychiatric illnesses did not commit violent crimes, however, those individuals who meet the criteria for mental illness have been found to be more likely to engage in violent behavior (NAMI, 2008; Schug & Fridella, 2015). The criminal justice system in all areas seems ill equipped to help those with mental illnesses on many levels (Human Rights Watch, 2003; Lurigio & Harris, 2007; Pettila, Ridgely, & Borum, 2003).

Policy changes such as passage of the *Community Mental Health Centers Act* in 1963 resulted in the deinstitutionalization of the mentally ill. Perez and colleagues (Perez, Leifman, & Estrada, 2003) explain,

Unfortunately, many states saw deinstitutionalization as an opportunity to save money rather than an opportunity to improve their mental health services. States closed down hospitals condemned for failure to meet the minimum constitutional standards of care for people with mental illnesses, but they did not use the money saved to develop community-based outpatient treatment centers or much-needed social services. The result has been nothing short of disaster. (p. 63)

The impact of deinstitutionalization has resulted in many mentally ill individuals being shifted from state hospitals to, or ensnared in, the criminal justice system. Additionally, get-tough-on-crime policies have resulted in harsher punishments for offenders where the focus is now on punishment, mass incarceration, and surveillance rather than rehabilitation and social inclusion (Garland, 2001). Garland (2001, p. 204) explains, "Mass imprisonment and private fortification may be feasible solutions to the problem of social order, but they are deeply unattractive ones. A large population of marginalized, criminalized poor may lack political power and command little public sympathy, but in aggregate terms they would have the negative capacity to make life unpleasant for everyone else." Thus, offenders who had a preexisting mental illness prior to incarceration or develop mental health problems while incarcerated are not likely to receive the treatment they need.

The systems put in place to respond to the deinstitutionalization of the mentally ill have created unintended consequences in the criminal justice system charged with addressing public health needs of people with serious mental illness including aggravated traumas that result in violence in interactions with criminal justice professionals from arrest through incarceration, resource allocation to first responders to provide Crisis Intervention Team (CIT) Training and financial burdens on local government to provide mental health care to people with complex problems, and enormous problems for the corrections system that must train staff to provide psychiatric care and provide and manage facilities in ways that keep staff and inmates safe while protecting civil rights of inmates with medical and mental health needs. Ultimately the criminalization of mentally ill has produced an “untenable situation” where funds are no longer available to support public mental health and jails and prisons have become “de facto psychiatric facilities” (Schug & Fradella, 2015, p. 500).

Apart from the lack of access to quality mental health treatment, offenders are reluctant to seek out treatment because they fear being labeled as weak or they feel the therapist cannot help them. Kenemore and Roldan (2006, p. 16) note that one offender explained the reluctance he/she felt in seeking help from a psychiatrist or pursuing therapy stating,

...it appeared to me that you had mental problems upstairs.” Some offenders perceive social distance between themselves and their therapists, which further inhibits successful treatment. For instance, one offender recalled, “I’ve gone to the counselors where they just went to school for that [a degree in substance abuse counseling] and never drank, never smoke, never did this, never did that. And they’re just sitting there trying to tell me something they learned out a book. (Kenemore & Roldan, 2006, pp. 16–17)

Further complicating successful reentry for those incarcerated with mental illness is *often* inadequate transition planning when they are released from jail or prison (Osher, Steadman, & Barr, 2003). These offenders need a wide range of available services that will meet their needs during reentry. Unfortunately, the lack of adequate transition planning for this group increases their likelihood of recidivating. Wilson and colleagues (2011), who examined recidivism rates for jail offenders in Philadelphia after a four-year follow-up period, found recidivism rates for those with severe mental illness were 54% compared to 60% of offenders with no such diagnosis. Not uncommonly, ex-offenders also report reintegrating into the community without mental health support. Given the intersectionality of mental illness and substance abuse problems, inadequate reentry planning and community support will ultimately lend itself to failure rather than success for ex-offenders (Rounsaville, Weissman, Kleber, & Wilber, 1982). Recidivism rates for offenders in aforementioned Wilson et al. (2011) study were 68% for those with a co-occurring mental illness and substance abuse problems.

It is apparently clear that ex-offenders must have critical needs, such as substance abuse and mental health treatment, met in addition to having other basic needs (ex., food, housing, ad employment) met, if ex-offenders are to be successful during reentry. However, previous researchers have not examined *both* ex-offenders and community corrections officers (CCOs) perspectives on factors facilitating successful ex-offender reentry—especially as it relates to the role of substance abuse and mental health treatment. Thus, this research investigation attempts to fill this gap through a qualitative research investigation and closely examines the role that substance and mental health treatment play in successful ex-offender reentry to better inform policymakers as to how these factors contribute to successful reintegration.

Method

The researchers of this study are university scholars who have published extensively on the topic of offender reentry and have presented on the topic in the community and at academic conferences at the local, national, and international levels. Both researchers have examined offending in a variety of contexts (e.g., prisons, work release centers, day reporting centers), have experience conducting research and facilitating programs in institutional and community correctional contexts, and recognize the importance of qualitative research in providing the necessary detail to inform the offender reentry process. That is, research relying solely on recidivism rates in explaining offender reentry are conceptually and practically incomplete. They are deeply committed to influencing positive changes for offenders based on their research findings. Meaningful policy actions based on qualitative findings are needed to modify the criminal justice system, and the researchers are committed to providing results that provide data beyond quantitative outcome variables such as recidivism rates that reveal the phenomenological experience of offenders available to practitioners and policymakers.

The authors utilize narrative analysis to understanding the complex dimensions of the lives of successful individual ex-offenders who have reentered society. The data presented is gleaned from 21 interviews with ex-offenders who have spent time in correctional facilities in Washington State and were subsequently released and 19 interviews with Community Corrections Officers (CCO) in Washington State in 2012. Prior to the interviews being conducted, approval was sought and granted by the Institutional Review Board (IRB) at Seattle University and the Research Review Committee at the Washington State Department of Corrections (WA DOC). Interview subjects were solicited through announcements that were sent out through various channels (e.g., Facebook, WA DOC Listserv, Criminal Justice Advisory Committee Listserv; Seattle Work Release Advisory Board Listserv), through local ex-offender support/referral agencies and community programs that involve ex-offenders, or through previous professional interactions¹. Those individuals who were interested in being interviewed contacted the researchers, and an interview date and time were selected and arranged by a graduate research assistant. All interviews were conducted at Seattle University in a faculty office². The interviews ranged in length from forty-five minutes to over one hour. The interviews were audio recorded with the permission of the subject. During the interview, the interviewer took notes via a computer. Following the interview, the notes were given to a graduate research assistant who transcribed the entire interview verbatim. Subjects were given a consent form describing the study and were asked to sign regarding their preference for having their name used or to have a fictitious name assigned to them for the reporting of results. Thus, names reported within this manuscript may or may not be the real interviewees' first names.

The majority of ex-offenders in our sample were male (67%) and all had spent time in Washington State correctional facilities and had been released. The majority of the interviewees were white (71.4%), followed by African-American (14%), Hispanic-American (10%), and Asian/Pacific Islander (5%). The crimes for which the interview subjects had been convicted most recently and for which they served their sentences were murder (33%, vehicular homicide (10%), assault/robbery (19%), drugs/theft/forgery (33%), and child molestation (5%). The number of years, directly preceding the interview, spent in jail/prison ranged from two to thirty ($M = 11$, $Sd = 8.7$), and the time since release ranged from one month to twenty-

¹ These outlets were chosen as the authors had contacts that were ex-offenders and practitioners. While this method was limiting, it allowed for an initial opportunity for the authors to obtain contacts with potential subjects. Once subjects made contact with the authors, the researchers asked subjects for referrals.

² Interviews were conducted at the university to protect subject anonymity as well as to assure subjects that the researchers were not at all affiliated with the Washington State Department of Corrections or their employer.

seven years ($M = 4$, $Sd = 6.1$). All but two interview subjects served their last period of incarceration in a prison setting. Two of the interview subjects served one year in county jail followed by a period of in-patient treatment or work release but had a history of short-term periods of jail incarcerations. The age at which the interview subjects reported they had first engaged in delinquent or criminal behavior ranged from thirteen to forty-two ($M = 19$, $Sd = 6.2$).

The majority of our CCO sample was male (57%) and overwhelmingly Caucasian. Our sample also included one African American, one Hispanic American, and two Asian American CCOs. Additionally, our sample ranged in age from twenty-nine to fifty-four years with an average age of forty years. Further, our sample had a range of years in service spanning from one to twenty-nine years with the average years of service being 8.5.

Interview Schedule

For all interviews of ex-offenders and CCOs, an interview schedule was utilized. Ex-offenders were first asked about their background regarding delinquent and criminal behavior and their history of incarceration and reentry. Then, ex-offenders were asked: *How long of a prison sentence did you serve and for what offense(s)? How long has it been since you have re-entered your community?* The second set of six questions asked about experiences during reentry. Ex-offenders were asked: *What were your initial experiences during reentry- Were any of these challenges/needs unexpected? What have your experiences been in regards to reentry- Does it differ at different point in reentry (i.e., initial versus several years later)? What do you attribute your success since release to? What things can be done both in-prison and in the community to further enhance reentry success? Is there anything else you would like to add regarding your success or on the topic of successful ex-offender reentry?*

CCOs were first asked about their educational background and work experience. Then, CCOs were asked: *What recollections of success stories do you have?; In your opinion, what are the primary factors obstructing the offender's ability to successfully reenter society?; In your opinion, what are the primary factors that contribute to an offender's ability to successfully reenter society?; Now that you have identified these primary obstacles and factors that enhance success, how do you help offenders address these issues in your work with them?; and What would help you assist ex-offenders in getting these met?* While an interview schedule was utilized to guide both of the interview sessions, interviewees were permitted to deviate from the schedule and add their own commentary and opinions about ex-offender reentry success anytime.

Results

Pinpointing Success Factors

Consistent with previous research on factors that can hinder or assist in reentry, housing, family support, sobriety, and mental health assistance were often cited by ex-offenders and CCOs as the foundation pieces to successful reentry (Brown, 2004a, 2004b; Fontaine & Biess, 2012, Gunnison & Helfgott, 2007; Helfgott, 1997; Helfgott & Gunnison, 2008). Both ex-offenders and CCOs identified having basic needs met, such as housing, as being important in the reentry process. Moreover, both pointed to the role of treatment for mental health issues as well as treatment, and cessation of substance abuse, as being important for successful reentry.

Kim, an ex-offender who had previously been unsuccessful in reintegrating into society after a prison sentence, recalls that previously he obtained a job in a shipyard. He described

his work environment at the shipyard at “nothing more than a field full of drugs.” While Kim had managed to stay away from drugs for about six months, he slipped back into using meth both snorting and smoking it. He has now acquired a “distaste” for meth and has made the decision not to use. For Kim, staying away from the illegal substances was critical for his success in reentering society. Bolt, another ex-offender simply states that “no drugs, no drinking” were the keys to his successful reintegration back into society. For Kim and Bolt, cessation of substance use was key to their success. Jill, an ex-offender with a drug history, attributes her success to post-prison education as well as a therapeutic community program which allowed her to work on herself and “defeating behaviors” that got in the way of her success in abstaining from drug use and other self-defeating behaviors that had the potential to put her back on the pathway to re-offense.

Interestingly, CCOs viewed housing as creating the foundation or platform for the ex-offenders to get a handle on substance abuse or mental health issues. Thomas, a CCO, described how having a basic need met such as housing can free ex-offenders to focus on what they need to do to be successful:

The first and probably most important thing is that they have housing. That they have a safe place that they can be so they can focus on the things that are going to make them healthy, mentally and physically. Focus on, if they have family, to make sure that those relationships are strong because that’s their support network. If they can focus on gaining insight into their mental illness, because obviously 90 percent of the time, it’s driving their involvement in the criminal justice system. You know, not accepting the fact that they are mentally ill and not taking their medicine, whatever it might be. So, housing tends to be the common dominator that we found for folks kind of as the starting point.

Kristyn, a CCO with five years of experience, further explained the role that housing can have in success,

What is huge for this population in particular is housing; I mean that is important for anyone, but when you’re working with people who have chronic mental illness and such a lengthy history, it is another compounding factor that keeps them from doing well in addition to being a convicted felon, in addition to having a history of homelessness; then they have this chronic mental illness and probably, maybe a drug or alcohol addiction with it. . . . I’ve seen housing be an amazing component to someone’s success and turn people’s lives around in a way you never thought...like a motel room would even do.

However, it became clear from the interviews that treatment was needed but was often lacking. Ex-offenders in our sample may not have had access to the mental health treatment or have received appropriate mental health treatment to address mental health issues. Dawn, an ex-offender, describes the problem of mental health assistance in prison which was less therapy and more medical management:

That’s one of the biggest problems in prison system. Not a lot of MH [mental health] available. I could get all the pills I wanted but I couldn’t get any help. I didn’t really want to start taking drugs because I was not into drugs so when I got out I did get really depressed.

While Dawn had access to mental health treatment, she felt that treatment involving her taking a different type of (legal) drug did not address her fundamental underlying mental health issues. Other ex-offenders in our sample were not getting the help that they may have needed upon reentering society. For instance, Donny, an ex-offender, feels mental distress when he ruminates about his prison experiences. He states: “When I get stressed out about prison... I never got raped in prison but I’ve seen a lot of violence...beat to death...I’ve got a lot of mental issues because of that...”

Donny states that his girlfriend suspects that he has post-traumatic stress disorder (PTSD), but he is unable to get the help he needs as there is no funding available for him for treatment. Thus, mental health treatment upon release is needed for ex-offenders so that they can better cope in society and address needs that they have with mental health care providers.

Success from the CCO Perspective

When we interviewed the CCOs, we asked them to recall success stories of ex-offenders that they worked with. Unfortunately, when asked, many could not recall any success stories, and if they were able to, most could only recall one success story. Some CCOs could not recollect whether any of their former clients were successful, or if CCOs could recall success stories, they usually only remembered one or two clients who were successful on supervision or shortly thereafter. However, for those CCOs who were able to recall client success stories, substance abuse and mental health treatment were pivotal elements of the success stories. For example, Lori recalls a former client, named Alex, who was a prolific car thief and methamphetamine user:

He was finally just realizing that “I have really got to get my act straight or I’m never going to have the life that I want to have” with his family. So he took a DOSA sentence, moved out of Snohomish County, moved down here to Seattle, did the treatment as required through DOSA. He stopped in the office. It’s been about a year ago. . . . He stopped by and gave a clean UA, and he stopped in to see a couple of us CCOs who he had also worked with. He came in and he was telling me he had a friend who financed him to have his own car repair shop. This was a guy who had been taking apart cars and rebuilding them for years. He got the tools for this car repair shop. His ex-wife and ex-girlfriend both allowed him to start having contact with the boys, and he actually had the boys for Christmas that year. He had been clean for two and a half years. A huge turn around. It was really cool. As we were walking out the door and saying good-bye, he pulls the door open as he says, “You know, B, all those talks with we used to have, they worked.” He closed the door and walked off. It was really cool. He really needed that extra shot, which he got through the DOSA program. But evidently something that I had said along the way, some of those thoughts helped him somehow, or he wouldn’t have made such a point to tell me that it helped.

Another CCO, Rebecca, mentioned the role of sobriety and avoiding criminal associates and even noted how perhaps age played a role in success, with middle-age ex-offenders doing better—although some seemed to be ahead of the curve:

One in particular right now and I have regular contact with him. Initially, he looks terrible on paper, he was a meth addict, he was involved in a lot of residential burglaries, manufacturing and dealing meth, so messy, so one of

those situations, that we don't see people come out of very easily. He is of the few people that I have seen come out of prison actually commit to completely changing their environment and people they spend time with and not falling back into the same behaviors. It's easy to hang out with the people you always hang out with. He made an active choice to stay away from them which is hard because Seattle is small. He went all the way through supervision without any violations, which is very impressive. He has been out for one year. He is now active in the community. He was one of those fellows that we did not expect to succeed. He is in his early thirties. We don't see them as being successful as those in the forties. They are tired. They're done. They don't have the same energy—they tend to age out. He was younger and was able to make a change.

For other CCOs, the success of their clients may be due to finally getting the mental health assistance that they need. Kristyn recalled,

I can think of another guy and he hasn't been on supervision for a long time. He was another guy who was very, very psychotic, always experiencing symptoms even when medicated. He was a violent, violent guy. He had an assault history and attempted murder. So, he was definitely high on our radar of people to watch. Because if he stopped taking his medication, he went go south pretty quickly. The problem with him that he, like a lot of people with pervasive mental illness, he would start to feel better and think that he could off his medication. So, he wouldn't show up for a couple of days and we'd get a call from Minnesota saying he was trying to get benefits there, and from Orlando, Florida. He just hopped on a bus and gone all the way across the country and trying to get benefits. Then we would have to issue warrant for him, extradite him back here. I think for him what was huge is that he moved into some partner housing that we have up in the U District, and the woman that owns that housing is this ninety-year-old woman who is the sweetest person you can ever meet, and she loves helping people out. So, he moved into this housing and I think it was that and finally just coming to realization that keep doing what he was doing; it wasn't working.

Oftentimes, people will be ordered to twelve months of supervision but if they're not complying it gets stretched out to two years to three years. He was that kind of guy. It was looking like it was going to take him six or seven years to finish eighteen months. But as soon as he got linked up with housing, he started volunteering and got a cat. . . . He's another person. He has lived in the same housing for last six years. He's never committed a new crime, nothing, not even trespassing. He's been done with supervision for years.

Denise, with over twenty years of experience as in the corrections field, stated:

I can think of a client I had who came onto my program. She's a mom of three kids. They're like eight, ten, and sixteen. Her husband was also convicted and went to prison. . . . She finally determined that what she needed was mental health help. She didn't necessarily know what; she just wanted to go talk to somebody just to kind of get some things out. In about a year's time, she had gone from her primary goal in life was how to get on her husband's visiting list

in the prison to “I’m not sure I want to stay with him. I’m not sure he’s the best interest for my kids.”

The perspectives of these CCOs suggest that reentry success may be enhanced through ex-offenders receiving the appropriate substance abuse treatment and mental health care. Once ex-offenders are able to achieve sobriety or achieve stabilization in their mental health status, then they appear to be better able to tackle the many challenges that await them on their path to successful reentry.

What Inhibits and Fosters Success?

It became apparent from our interviews with both ex-offenders and CCOs that the nature of navigating the system, access to treatment, and access to quality of treatment providers may inhibit ex-offender reentry success. In regards to what needs to be done to foster reentry success, Steve, an ex-offender, explains:

In prison. Department of corrections needs to stop waiting until the last 18 months of the person’s time to make available drug and alcohol treatment. If they want to start on day one they should let them start day one. I had to file a grievance to start treatment...I started 1997 the NA and AA but the actual treatment didn’t come until 2000.

For Steve, the access to substance abuse treatment in a timely manner without bureaucratic entanglements is needed. Dawn, an ex-offender stresses that more is needed to help women in prison. She explains that mental health treatment is needed and “unless you have a serious mental disorder and need some type of counseling it’s very hard to get counseling.” Other ex-offenders note that programs in prison may waste their time. Sarah, an ex-offender explains, “These women sit around and sleep and watch Jerry Springer all day long... There’s nothing...these drug addicts who don’t do anything in society come in there and don’t do anything...free food...talk shit...do nothing...war stories... its horrible. If you don’t want to change you don’t have to.” Another ex-offender Jill explains that it is “so hard to get mental health treatment or chemical dependency treatment.”

Dolphy, an ex-offender, stresses the need for quality reentry classes. He states,

What I would like to see inside prison is not the little bullshit reentry classes they have in there now which is a little pamphlet with somebody who doesn’t even know what they’re talking about sit in class once or twice a week.

He stresses the need for practical educational classes that help ex-offenders cope with real life situations.

Feedback from the CCOs identified bureaucracy and quality of treatment providers may inhibit ex-offender reentry success. When asked about primary factors inhibiting success, Lori, a CCO, explains,

Bureaucracy. When they have to wait for four to six weeks to get into in-patient treatment, and they’re meth addicts, they’re not going to make that appointment to get that next level, and it’s not anything against the treatment program. We don’t have the space, the funding, all that kind of stuff.

She added regarding the bureaucracy surrounding getting mental health needs met:

Or they go to jail for thirty days and lose their medical coupon and it takes them three to four weeks to get their medical coupon back before they can get back on their medication. By that time, they have spiraled downhill enough that they've gone out and done something else.

We also queried the CCOs to determine what else could be done to foster successful reentry for ex-offenders. Chris T. pointed out the lack of quality treatment:

Quality of providers that are out there. Across the board, whether it's chemical dependency, sex offender, and mental health. Just from working with all of them, there's just some people that just shouldn't be doing this stuff. I see a lot of providers in the sex offender level. I'm a lot biased there. There's a lot of people out there that shouldn't be doing it. And the definition of what exactly are they providing, sometimes they just sit in a chair. Who really knows what they're providing. I read a progress report and I am thinking what are they doing? And then you get another report from another provider, and I can see that this person's doing clinical work. I don't know what all these words mean. There's a gap amongst providers. A lack of, actual lack of services. Because not everyone can access services.

The need for wraparound services, or services that are individualized that meet ex-offenders' needs and are carefully planned and managed, was also mentioned by several CCOs. Brad explained,

Wraparound services for every guy coming out. Honestly, I'd say the first forty-eight hours of release, that's the most crucial time. Unfortunately, the prison system is so overloaded that we can't provide that for everybody coming out of the prisons.

For some CCOs, funneling additional monies into programming is a much-needed priority for ex-offenders today. Kelley explained,

I think money needs to be put into programs to support the offenders when they get out and then once they're off supervision. They'll be in a better place if they'd have mental health treatment or . . . look at the sex offender population, their treatment is just so expensive, and you know, the treatment when they're on supervision and they're compliant for the most part and they do well, it's something that's really positive that these guys need to be in and need to go through, but if you can't afford it, you're in violation and then you can go back.

In sum, both ex-offenders and CCOs brought up the issue of bureaucracy as a factor that stymies success. As ex-offenders navigate through red tape, they are often losing valuable time to address substance abuse and mental health issues. Additionally, both identified the lack of access to quality treatment. Some ex-offenders had access to treatment, but the access was limited and not of quality. This quality concern was raised in regards to treatment both inside the prison walls and in the community.

Discussion

Successful reentry is a difficult goal for most ex-offenders to achieve and CCOs often have difficulties in assisting their clients due to bureaucratic red tape. Despite these facts, results from interviews with both ex-offenders and CCOs have yielded the importance of substance abuse and mental health treatment and both have identified these treatments as being critical keys to successful reentry. That is, beyond basic needs being met, such as housing and food, ex-offenders are in need of treatment both inside the institutional walls and beyond the iron gates. It should be noted, however, that housing was a critical piece of the foundation that some CCOs identified as paving the way for reentry success in that it allowed the ex-offenders to focus on the larger issues that were contributing to their criminal involvement. With housing being such a critical piece to providing a foundation for reentry success, community members that oppose offenders residing in their communities unintentionally thwart opportunities to enhance reentry success (Garland, Wodahl, & Schuhmann, 2013; Kilburn, Costanza, Frailing, & Diaz, 2014).

Our results indicate that, for ex-offenders who are incarcerated, the treatment needs to start sooner as opposed to later. That is, treatment plans for those who are incarcerated who suffer from these issues should be developed and implemented on “day one” as they enter the institutional facility. All too often, the treatment begins much later resulting in lost time for the individual to get the help that they need and get on the road to recovery. The loss of valuable time for treatment to commence was also illuminated by CCOs. Several of the CCOs spoke of gaps in treatment when ex-offenders were reentering the community often due to bureaucratic red tape. The passage of the *Affordable Health Care Act* in 2011 will provide better access for ex-offenders to health care, but it should not be viewed as a panacea for the health care problems faced by ex-offenders (Phillips, 2012). With states just beginning to plan and implement ACA policies, it remains to be seen whether the act will assist disadvantaged groups, such as offenders, as it was intended to (Phillips, 2012).

For those incarcerated offenders, the treatment needs to be of quality. All too often, treatment was viewed by ex-offenders to be a waste of time or not helpful. Frisman and colleagues (2010, pp. 4-9) suggest that for mentally ill ex-offenders, “in particular, high-quality outpatient behavioral health care services—including medication management, supportive services, respite care, and vocational rehabilitation—will help reduce homelessness, recidivism, and the need for emergency room visits and hospitalization.” Thus, the gap in quality of treatment services is a huge concern. This sentiment of subpar treatment programs was echoed by CCOs as well. That is, CCOs reported that many clients on their caseloads were lacking quality treatment care in the community. In fact, one CCO questioned what treatment his/her client was actually receiving when reviewing case notes from the therapist. In order to facilitate successful reentry, ex-offenders must not only have access to treatment but also receive quality treatment—program integrity does indeed matter (see Lowenkamp, Latessa, & Smith, 2006). Given this, policymakers and the public must be willing to monetarily invest in quality programming.

Furthermore, the needs and challenges identified in this study highlight the critical importance of working to identify the ways in which failures in properly treating mental illness in correctional contexts perpetuate and compound a never-ending cycle of social dysfunction. When untreated offenders with mental health problems are released from prisons or jails, they re-enter society and only to become well known to law enforcement as “high system utilizers” or “frequent fliers” who place extraordinary burden on resources at the front-end of the system (Andrews & Baldry, 2013; Helfgott, Hickman, & Labossiere, 2016). Future research examining the overlap between individuals seen by law enforcement as frequent fliers who are in behavioral crisis who come into contact with police and mental health agencies and those

who have spent many years trying to manage their mental illness within correctional systems is needed to identify points of perpetual dysfunction in the criminal justice process. The needs and challenges that ex-offenders experience in the reentry process, coupled with the additional needs and challenges of mental illness, substance use disorders, and general mental health management are complex and unique. A greater understanding of the intersection of the experience of reentry and the management of mental health issues is an important area for future research.

While this study offers insight into the importance of substance abuse and mental health treatment, it is not without its limitations. This study utilized a small availability sample, and, thus, generalizability is limited as a result of the nature and size of the sample. A larger sample could have yielded additional information about the role that substance abuse and mental health plays in successful reentry. Another limitation of the study is that only ex-offenders and CCOs from one state were interviewed. A more national and diverse sample may have provided a deeper understanding of the role of treatment for ex-offenders across the nation at various stages of reentry. Additionally, a more national sample may have highlighted further service adjustments that may be needed both institutionally and in the community. Finally, only individuals who had successfully entered the community were interviewed, thus, by not interviewing incarcerated subjects who have failed, other factors of what can contribute to failed reentry may have been missed.

Despite the limitations of the study, the research offers qualitative data that provides a nuanced understanding of the hierarchy and interrelationships of needs and challenges ex-offenders face that provide clear and solid policy implications. First, substance abuse and mental health treatment must be a critical component for ex-offenders both inside prison walls and in the community. Offenders are in great need of assistance in addressing these issues and policymakers should not lose sight of this fact. While meeting basic needs is important, ex-offenders need assistance beyond that if they are expected to successfully reentry society. Second, treatment needs to be offered in a timely manner. Treatment should begin for ex-offenders the moment they enter a prison or step foot back into the community. Gaps in treatment hinder ex-offenders' ability to successfully reintegrate back into society. States and Departments of Corrections should work together and evaluate where gaps in treatment lie and seek to find methods to mend the gaps. If departmental policies and procedures are slowing down the access to treatment, then these policies and procedures need to be revised. For example, in the city of Seattle the Neighborhood Correction Initiative (NCI) partners law enforcement officers with community corrections officers in teams that rely on shared knowledge of individuals who come into contact with police who are under correctional supervision to enhance public safety. Research on the intersection of mental illness, substance abuse, and reentry can inform the services provided by these sorts of law enforcement-corrections collaborative initiatives (Washington State Department of Corrections, August 8, 2013). Finally, treatment programs need to be of quality. Treatment programs within the prison should be routinely evaluated to determine if they are meeting the needs of participants. Such evaluations would allow for program modifications or adjustments to ensure that service quality is high. Similarly, outside the prison walls, evaluations or reviews of treatment providers should be conducted to ensure that ex-offenders are receiving the quality treatment that they need.

More specifically, NIDA (2012) recommends that for those with substance abuse addictions that treatment be sufficient in length, tailored to the needs of the offenders, and target other factors related to criminal involvement. Additionally, Hammet, Roberts, and Kennedy (2001) identify five factors that can assist mentally ill ex-offenders in reentry: (1) discharge planning, (2) adherence to treatment regimens, (3) available housing, (4) quick access to benefit programs (e.g., Medicaid), and (5) access to help for managing multiple

diagnoses (e.g., those having co-occurring disorders such as mental illness and substance use). These treatment principles would also apply to those with substance abuse problems.

In sum, this research investigation serves as a springboard for future research investigations into the role that substance abuse and mental health treatment play in successful reentry and the interrelationship of needs and challenges that ex-offenders are faced with upon release and the ways in which particular needs and challenges (e.g., lack of housing, timing of treatment interventions) can be moderating factors that influence successes in other areas (e.g., completion of mental health and substance abuse treatment). Future researchers should expand on this investigation using a larger sample of ex-offenders and CCOs with attention to the interrelationship between needs and challenges faced by ex-offenders and the ways in which particular needs and challenges act as moderated variables that have the potential to derail or enhance reentry success. Further, this research provides several key recommendations that should be considered by policymakers. If successful reintegration of ex-offenders into communities is desired in the reentry process, policymakers must go beyond ensuring that ex-offenders' basic needs are met and support treatment for both substance abuse and/or mental illness from a holistic perspective that acknowledges that substance abuse and mental health needs are intertwined with the many other individual and situational needs and challenges that arise in the reentry process. Effectively addressing mental health and substances abuse issues in reentry requires ensuring that basic and individual needs are met. Further, individualized attention to the interrelationship of particular challenges that have the potential to positively or negatively impact mental health and substance abuse treatment success also needs to be addressed to foster success in the reentry process.

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Article Citation

Gunnison, E., & Helfgott, J. B. (2017). Critical keys to successful offender reentry: Getting a handle on substance abuse and mental health problems. *The Qualitative Report*, 22(8), 2152-2172. Retrieved from <http://nsuworks.nova.edu/tqr/vol22/iss8/5>
