



Reentry and Offenders with Special Needs:

MENTAL ILLNESS AND ADDRESSING CRIMINOGENIC NEEDS

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With the current state of corrections, the response to offenders with special needs continues to be a concern, and the lack of literature and data reaffirms the need to address the reentry process for this population. In a system that is fragmented even as it is designed for public safety, the lack of coherent goals places offenders with special needs at an extreme disadvantage. Although the leadership in the criminal justice system does make a concerted effort for developing and executing effective evidence-based

models for offenders returning to society, better approaches are still needed and at a more progressive pace.

The percentage of offenders who suffer from mental illness is unclear. According to reports from the Bureau of Justice Statistics (BJS), an estimated 56% of State, 45% of Federal, and 64% of adults incarcerated in jail suffers from mental illness (Bureau of Justice Statistics, 2006). Statically, 10% to 19% of the jail population contains mentally ill offenders. In addition, 18% to 27%

of State prison populations and 16% to 21% of Federal populations suffer from a serious mental illness (SMI), including schizophrenia, major depression, bipolar disorder, and schizoaffective disorder (Litschge & Vaughn, 2009).

A great proportion of that population also suffers from co-occurring substance-use disorders (Bureau of Justice Statistics, 2006). These statistics are alarming considering that in the United States, there are three times more individuals in correctional facilities suffering from mental



The goal in every correctional facility and housing unit is to improve an offender's behavior while in custody and after being released to the street. There are different approaches and discussions on what factors can be changed and what is the best approach (Latessa, & Lowenkamp, 2005).

Several studies have revealed six major risk factors for criminal conduct (both in the jail and on the street):

1. Anti-social and pro-criminal attitudes, values, and beliefs.
2. Pro-criminal associates.
3. Temperament and personality issues.
4. History of behavior.
5. Family issues.
6. Low levels of education, vocational training, and financial issues.

Risk factors that cannot be changed (static):

- Prior criminal or inmate record.
- Age when first placed into a jail (arrested for first violent crime—age 10).
- Family issues—father and other relatives are in prison (may explain why the inmate is in jail).

Risk factors which can be changed (criminogenic needs):

- Anti-social behavior.
- Anti-social peer associations.
- Substance abuse.
- Lack of empathy.
- Lack of problem-solving.
- Lack of self-control skills.
- Anger management issues.

Offenders with a single risk factor may only present a minimal problem. Inmates with two or more risk factors increase the possibility of criminal behavior both in the jail and on the street. The more risk factors that are present, the higher the possibility (Latessa & Lowenkamp, 2005).

When looking at rehabilitation and recidivism, programs that focus on four to six criminogenic factors

have a 30% or more effect on the individual. Some rehabilitation programs focus on:

- Fear of punishment.
- Physical conditioning.
- Self-esteem.
- Understanding of one's culture or history.
- Creative abilities.

However, programs that mainly focus on these issues have had little effect on recidivism. A rehabilitation program has to combine these approaches with the criminogenic needs in order to be effective (Latessa, & Lowenkamp, 2005).

Criminogenic Needs and Barriers

An attempt to respond to the overwhelming amount of offenders released to the community reveals that a system-wide endeavor is needed for addressing criminogenic needs. Wells (2015) states judicial systems and mental health service providers are inadequate and incompetent for handling offenders with mental health issues. For example, barriers that exist within reentry and the judicial system are typically caused by procedural deficiencies that affect the outcomes of receiving fair and impartial court procedures (Wells, 2015).

Barriers include a lack of sufficient transportation, breakdown in communications, inadequate treatment plans for reentry, and medical records (Wells, 2015). These barriers contribute to the ongoing failure of addressing the criminogenic needs of the offender, the viable need for community support, and activism for those affected by such a fragmented system. The disadvantage of the unmet needs inherently perpetuates the cycle of criminality and complicates the reentry process.

Female Offenders and Reentry

Spjeldnes, Jung, and Yamatani (2014) recommend an assessment of reentry barriers from gender specific needs: Women in particular were increasingly facing issues

illness than in mental health hospitals. Offenders are two to four times more likely to suffer from a mental illness than members of the general public (Human Rights Watch, 2003; Litschge & Vaughn, 2009).

Criminogenic Behaviors

Criminogenics is the study of attitudes and beliefs of criminal offenders. Rehabilitation is based on those aspects of the offender that can be changed (and what elements cannot). It is important to understand their motivations and beliefs about committing crime.

due to the failure of not addressing past behavioral issues such as drug dependency. Women were also more likely to have low educational attainment and lack of employment prior to incarceration, which leads to unsuccessful reentry after being incapacitated for some period (Spjeldnes, Jung, & Yamatani, 2014). Based on a literature review of gender differences, demographics, life circumstances, and needs, Spjeldnes, Jung, and Yamatani (2014) asserted that women would have greater difficulty with transitioning into the community.

This is complicated by the codependency of drugs and alcohol, lack of parenting skills if children are involved, and inadequate employment and vocational opportunity. Spjeldnes, Jung, and Yamatani (2014) revealed that women showed a great need for health and reentry treatment, but men were still more likely to commit violent crimes and have higher recidivism rates. An anomaly appeared to be with women who were seeking or experiencing 12-step programs and assistance as opposed to men, which influences the outcome of reentry services.

Mentally Ill Offenders

Researchers proposed that mentally ill offenders are more likely to be rearrested within 18 months of release than offenders with no mental illness. The Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments, recommended that reentry services for mentally ill offenders start at the beginning of their incarceration to ensure better access to all needed services (Council of State Governments, 2002; Couturier, Maue & McVey, 2005). In 2004, President George W. Bush signed the Mentally Ill Offender Treatment and Crime Reduction Act. This law recommended "using jail diversion and community re-entry programs as the best practices for reducing the increasing incarceration of adults and juvenile offenders with

mental illness" (Litschge & Vaughn, 2009, Steadman & Redlich, 2006).

Reentry for Mentally Ill Offenders in Illinois

Steadman and colleagues (2009) reported the percentage of inmates suffering from serious mental illness in Chicago, Illinois in 2007 was 6.4% for male inmates and 12.2% for female inmates. Much emphasis in the past decade has been placed on developing programs that facilitate the reentry of mentally ill offenders to their communities of origin. However, there are more demands for services than there are reentry programs available for mentally ill offenders (Human Rights Watch, 2009).

In addition, to be most effective for the mentally ill offenders, reentry programs need to know "about criminal statutes and sentencing decisions; court operations and exigencies; and parole mandates, policies, and procedures... to develop effective skills for addressing the criminal behavior of their clients" (Lurigio, 2001; Lurigio, Collins, & Fallon, 2004). Across the country, several community organizations have responded to the call of beginning the reentry services before an offender's release. One such program is the Thresholds' Justice Program in Chicago, Illinois. They have been able to demonstrate that their "services yield an 89% reduction in arrests, 86% reduction in jail time, and 76% reduction in hospitalizations" (Thresholds, 2015).

Established in 1997, Thresholds' Justice Program provides transitional services to people with severe mental illness who are exiting Illinois Dwight and Dixon Correctional Facilities in the Illinois Department of Corrections (Lurigio, Collins & Fallon, 2004). Thresholds (2015) establishes: "Prior to a prisoner's release, our skilled and experienced staff connects this at-risk population with community-based housing, primary physical and mental health care treatment

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(including medications and medication monitoring), job assessments and placement. Other program outcomes include increased community reintegration, as evidenced by independent living, reconnection with family, employment, education, and decreased symptoms of mental illness and substance use."

Thresholds' Justice Program is loosely based on the Assertive Community Treatment (ACT) model. The ACT model provides intensive case management services in a team approach to individuals with serious mental illness at home and community (Scheyett, Pettus-Davis, & Cuddeback, 2010). In the community, ACT provides services with a full clinical mental health staff including a psychiatrist, nurses, substance abuse specialists, and case managers. The team encourages consumers to stay involved in their treatment and assertively works in homes, neighborhoods, and places of employment as needed to provide services and promote recovery. Similar to a hospital unit, the staff holds daily team meetings and provides services throughout the day and evening seven days per week (Brown, 2004).

Studies have shown the effectiveness of the ACT model in reducing homelessness, rearrests, psychiatric hospitalizations, and increasing compliance with treatment (Brown, 2004; Davis et al., 2008; Lurigio, Collins & Fallon, 2004, 2004; Scheyett, Pettus-Davis, & Cuddeback, 2010). The ACT model remains a viable option for offenders with mental illness reentering the community.

Reentry Successes

In order to succeed, reentry for mentally ill offenders needs to coordinate a range of specialized services that includes but is not limited to (Lurigio, Collins, & Fallon, 2004):

- Integrated mental illness and substance treatment.
- Primary healthcare and mental health healthcare.
- Housing and financial resources.

- Childcare.
- Employment referrals.
- Vocational training.
- Family and community involvement.

Wilkinson (2005) stated, "It is vital that correctional agencies work with community organizations whose expertise involves employment readiness, workplace culture and knowledge of job opportunities that commences at the outset of an offender's incarceration, thus preparing him or her for meaningful future endeavors."

Wells (2015) described an urgent need for Federal agencies to collaborate and unify in a manner that addresses the barriers facing an offender with severe mental illness. The effort ensured each agency, U.S. Marshal's service, Federal Bureau of Prisons, U.S. Probation, and Utah Federal Defenders, implemented positive changes to the procedural barriers that improved their mission and vision (Wells, 2015). In Utah, as well as other places such as Chicago, the essentials for addressing criminogenic needs and the offenders who are suffering mental illness and/or co-occurring disorders are proving to be effective through a comprehensive approach that services all aspects of living in the community (Hatcher, 2007; Wells, 2015).

Housing, viable treatment modalities, awareness, mental, and emotional or spiritual support are some of the issues that offenders must attend to while reentering society (Hatcher, 2007). Elements of the reentry process need to be handled through a collaborative effort with an intent of making a collective impact. Failure to aggressively attend to the reentry needs of inmates, especially those who suffer from mental illness, results in an increase in recidivism and continued hardship of the offender. ■

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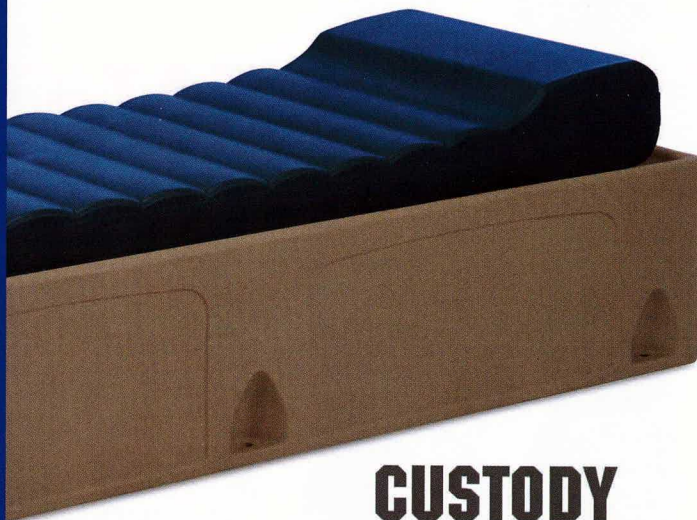
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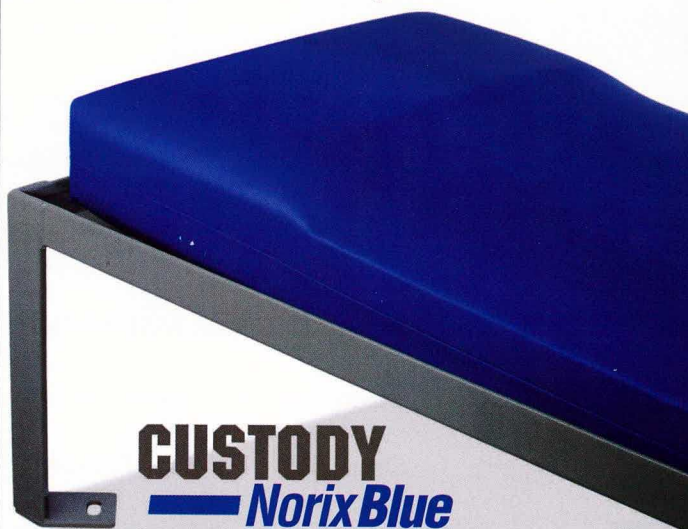


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