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LITERATURE REVIEW

Societal Reentry of Prison Inmates With Mental Illness: Obstacles, Programs, and Best Practices

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Abstract

Societal reentry from prison presents a wide array of extreme challenges to inmates attempting to reintegrate with society. This process is significantly more daunting for inmates suffering from mental illness for several reasons. This paper examines the reentry process for inmates with mental illness. Three sample reentry programs (Forensic Assertive Community Treatment, Critical Time Intervention, and Thresholds' Prison Aftercare Program) that were developed for inmates with mental illness are discussed along with research testifying to the effectiveness of these programs. Finally, components that would comprise an ideal prison reentry program for mentally ill inmates are outlined, which include a three-phase structure and a focus on preparing both inmates and communities for the reentry process.

Keywords: prisoners, reintegration, severe mental illness, release planning, best practices model, reentry

Introduction

Few would dispute the notion that achieving successful reentry into society after an extended stay in prison is an extremely difficult process fraught with countless obstacles. Among those hurdles are access to adequate health care, acquisition of gainful employment, identification of affordable housing, and successful reintegration into the family and community. As challenging as the reentry process is for inmates in general, it is even more difficult for those with mental illness. These inmates face all the aforementioned obstacles but often to an even greater degree. This phenomenon is reflected in statistics revealing that mentally ill releasees are significantly more likely than their mentally healthy counterparts to recidivate (Baillargeon *et al.*, 2009). Additionally, severity of mental illness has been correlated with likelihood to recidivate (Bales *et al.*, 2017). One major contributor to this statistic revolves around housing concerns. Inmates with mental illness are more likely than those without mental illness to be homeless after release (Herbert *et al.*, 2015). Common causes for homelessness among these inmates include lack of adequate community-based treatment programs, difficulty obtaining employment leading to financial inability to support housing, psychotic symptoms interfering with the organizational abilities required to obtain stable housing, and substance abuse resulting in allocation of financial assets to drugs over housing (Draine *et al.*, 2002; Folsom *et al.*, 2005).

Employment outcomes are also much poorer for mentally ill inmates both before and after incarceration (Baillargeon *et al.*, 2010). In a 2008 study of ex-prisoners in Ohio and Texas, 53% of men and 35% of women without mental illness were legally employed (which excludes ''under-the-table'' work as well as working for a family member or friend) within 8 to 10 months of release, but among mentally ill ex-prisoners in the same samples, only 28% of men and 18% of women were legally employed.

There are three primary barriers that individuals with mental illness face when seeking and maintaining employment, regardless of the additional factor of a criminal history. The first is the interference of the illness itself with achieving occupational and social functioning levels necessary for the job (Baron & Salzer, 2002). For example, depressive symptoms can negatively impact energy and overall mood; various disorders, including psychotic disorders, may cause interpersonal skills deficits that affect work relationships and client interactions; and cognitive deficits can hinder an individual's ability to solve problems and complete required work tasks (Baron &

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Salzer, 2002). The second barrier is inaccessibility and inadequacy of mental health rehabilitation programs with an occupational focus (Baron & Salzer, 2002). The third is employer discrimination (Batastini *et al.*, 2017). Although the Americans with Disability Act offers protection from many forms of discrimination, informal discrimination, including negative workplace attitudes toward those with mental illness, still persists and is often not actionable.

Along with employment, housing, and other living concerns, inmates with mental illness face the need to seek mental health treatment or else struggle with untreated psychopathology. Unfortunately, psychological treatment offered in communities is often fragmented, with each treatment provider preferring patients without serious mental illness comorbidity (Lurigio *et al.*, 2004). As a result, many released inmates will have great difficulty finding affordable treatment that caters to their individual combinations of mental disorders, and many will never find adequate mental health treatment (Baillargeon *et al.*, 2010).

Another problem released inmates with comorbid substance abuse and other mental illness face is treatment prerequisites. Many drug treatment programs are either unwilling or unprepared to treat patients with other mental health diagnoses (Lurigio *et al.*, 2004). To further complicate treatment problems, many mental health treatment centers require abstinence from substance use before initiating treatment (Lurigio *et al.*, 2004). With such an impasse present, some inmates give up on seeking treatment and choose instead to cope as well as possible with their mental illnesses, including through self-medication with illicit drugs. Forgoing treatment may be part of the reason inmates with serious mental illness, such as major depression and psychotic disorders, recidivate and, on average, return to prison one year sooner than inmates without serious mental illness (Cloyes *et al.*, 2010). Another reason for quick return to the criminal justice system among the mentally ill is substance use. Those addicted to illegal substances may begin to seek out the substances again, and drug charges can add up and lead to another stay in prison. In fact, studies regarding risk assessment for future violent behavior consistently note that substance abuse multiplies the likelihood of such behavior by a factor of three (Monahan & Steadman, 2001). Quite frequently, when the general public speaks of mentally ill people committing violent crimes, they fail to understand that when violence does occur in this population, it is often due to the interaction of substance abuse and mental disorder (Monahan & Steadman, 2001).

Due to the increased difficulties mentally ill inmates face upon release, these inmates are much more likely to return to incarceration after they are released compared to their mentally healthy counterparts. In fact, research has shown that inmates with major psychiatric disorders, including depressive disorders and psychotic disorders, are twice as likely to undergo two or three additional incarcerations (Baillargeon *et al.*, 2009). According to the risk-need-responsivity model of service delivery, optimal treatment results are achieved when resources are proportionately allocated to those individuals who pose the highest risk for recidivism and who demonstrate the greatest needs in facing the reintegration process (Morgan *et al.*, 2012a, 2014). Inmates with mental illness clearly fall into this category. However, it is often the non-mentally ill inmate who is provided with more community reentry opportunities rather than the mentally ill inmate who has the greater need.

Typical Prison Reentry Models

A prison prerelease reentry program can be defined as services that ''specifically focus on the transition from prison to community or initiate treatment in a prison setting and link with a community program to provide continuity of care'' (Petersilia, 2004, p. 5). Under this definition, all 50 states in the United States offer federal and state prisoners some form of reentry program (Austin, 2001). Naturally, programs vary widely in their offerings from state to state. However, most programs have a similar core structure that centers on academic education, job and/or skills training, substance abuse education and/or treatment, and education on community resources that aid with the transition process and continuity of care (Austin, 2001). It is notable that, when treating substance abuse, the treatment of the underlying mental illness does not appear to be central to these rehabilitative efforts. In fact, these rehabilitative efforts, while laudatory, essentially constitute case management and do not address any underlying mental illness that may be present.

Direct financial assistance is also commonly offered upon release, but this money is only intended to provide for immediate needs and likely will not last longer than a day or two. Programs tend to offer within a range of $25 to $200 plus at least one set of basic clothing and enough money for the inmate to take public transportation home or to the county of his or her original sentencing (Austin, 2001). Once released inmates have been transported to their communities of origin, they are almost always on their own from that point forward to seek out services and reintegrate themselves into society.

Programs Designed to Accommodate Mentally Ill Inmates

Several programs have been developed and implemented that are designed specifically to cater to mentally ill inmates as they prepare and undergo reentry. These programs are still in their relative infancy and have yet to be widely accepted, funded, and more broadly applied. However, they appear to show promise in their ability

to prepare mentally ill inmates for the reentry process, bridge the gap between in-prison treatment and community treatment, and reduce recidivism rates.

Forensic Assertive Community Treatment

Assertive community treatment (ACT) is a model developed in the early 1970s with the goal of integrating hospitalized individuals with severe mental illness into the community. This model has been successfully implemented in at least 33 states since its inception (Dixon, 2000). This intensive program focuses on maintaining its participants' psychological stability and maximizing their capacity for daily independent functioning without relying on the structure of any institutional setting. Its core components feature the following: multidisciplinary treatment teams, low patient-to-staff ratios (ideally 10:1 or less), home visits, around-the-clock patient access to staff, assertive outreach to reluctant patients, and individualized approaches to treatment needs (Bond *et al.*, 2001). A particularly unique aspect of ACT is its time-unlimited nature; that is, patients remain as participants in the program for life, though their services may be tapered off to reflect their recovery.

After decades of its successful application, the ACT model evolved to serve incarcerated individuals as well, and forensic assertive community treatment (FACT) was born (Lamberti *et al.*, 2011). FACT adjusts the focus of treatment to preventing future incarcerations and usually involves the patient's parole officer as a member of the multidisciplinary treatment team (Lamberti *et al.*, 2011). The parole officer undergoes mental health training prior to engaging in the program, which has been shown to increase agreement between officers and other members of the team when making decisions regarding the patient's treatment and/or potential disciplinary action (Heilbrun *et al.*, 2017).

FACT has been implemented in various communities across the United States and has enjoyed general support of its efficacy from the research community. A 2010 study conducted in California found that participants in FACT were significantly less likely to be rearrested than their peers in a control group in both the first and second years following release (Cusack *et al.*, 2010). Other research has confirmed this pattern among participants of FACT programs implemented elsewhere (Heilbrun *et al.*, 2017; Lamberti *et al.*, 2011). Another study revealed remarkably encouraging results, with positive outcomes related to multiple domains, including ''non-reoffending, psychiatric stability, substance abuse abstinence, stable housing and meaningful activity'' (Smith *et al.*, 2010). Benefits of FACT programs often attributed to their success in reintegrating their participants into the community include collaboration with criminal justice systems and offering mental health services internally (Angell *et al.*, 2014).

Critical Time Intervention

Critical time intervention (CTI) is a program that was initially designed to be implemented with homeless populations to provide resources and increase logistical and emotional stability for the transition from homeless shelters to independent living (Draine & Herman, 2007). It has recently been restructured to cater to the prison population based on the same principles. It is a ''nine-month, three-stage intervention that strategically develops individualized linkages in the community and seeks to enhance engagement with treatment and community supports through building problem-solving skills, motivational coaching, and advocacy with community agencies'' (Draine & Herman, 2007, p. 1577). This program provides several of the usual transitional services, such as vocational training, but there is a key focus on the critical factors of community and social support in reentry. CTI helps inmates form ties to long-term service providers, but it also works with family and friends to develop healthy and effective relationships conducive to recovery and psychological stability. Most mentally ill inmates rely on their social supports upon release, and CTI helps prepare those close to the inmate to be the best possible facilitators of continuity of care and psychological health (Draine & Herman, 2007). CTI itself serves as a temporary support system until the inmates can achieve their highest potential level of independence.

The first phase of CTI is transition into the community. It begins with an assessment of the inmate's concrete needs, psychological needs, and individual strengths (Herman & Conover, 2002). Program staff create an individualized plan that specifically considers the following areas of concern: ''psychiatric treatment and medication adherence, money management, substance abuse management, housing crisis management, and family interventions'' (Herman & Conover, 2002). The treatment plan is optimized around these components in an effort to maximum each participant's potential for stability. Once a plan is established, program staff focus on linking the individual to the most appropriate community resources to address the assessed needs in each of the aforementioned areas. This may include psychiatric care, vocational training, or halfway houses, among other resources (Herman & Conover, 2002).

The second phase of CTI is a ''try-out'' phase. Its goal is to maximize the participants' independence (Herman & Conover, 2002). In this phase, program staff carefully observe the individual's use of community resources while intervening with assistance only when it is deemed necessary. Individuals in this phase are expected to rely on their strengths that were identified in the first phase and independently find ways to compensate for their weaknesses sufficiently to adjust to their community and continually make use of treatment resources as necessary. Assessment of changing needs and strengths continues in

this phase, but staff allow participants to make their own adjustments to their treatment plans as necessary in order to further foster independence (Herman & Conover, 2002).

The final phase is transfer of care (Herman & Conover, 2002). Program staff spend this portion of the program ensuring that the participant's links to community resources are secure and that these resources will be able to provide for the individual's needs well beyond CTI termination. Additionally, they ideally arrange meetings with members of the participant's life who are invested in their long-term reintegration into society, including treatment providers and family members, and discuss facilitation of the individual's achievement of long-term goals. Finally, staff psychologically prepare the participant for termination from the CTI program to alleviate any potential emotional difficulties that may arise when terminating the therapeutic relationship (Herman & Conover, 2002).

Because CTI has been applied to prisoners only in very recent years, little research has been done on its effectiveness with inmates. However, a pilot study was conducted in 2012 to examine the power of CTI to improve outcomes in terms of social, clinical, housing, and welfare services linkages (Jarrett *et al.*, 2012). The researchers implemented CTI in three prisons in England and compared those who completed CTI to those who underwent treatment as usual, which essentially entailed basic discharge planning. The study found that inmates who participated in CTI were about three times as likely to be in contact with mental health services; about four times as likely to be registered with a general practitioner, receiving medication, and benefitting from welfare services; and almost twice as likely to be in contact with their families upon release compared to inmates receiving treatment as usual (Jarrett *et al.*, 2012). Housing outcomes were fairly similar, although none of the participants in the CTI group were homeless at the follow-up compared to one participant in the treatment as usual group (Jarrett *et al.*, 2012). Overall, CTI appears to be a promising treatment model for prison inmates due to its dual focus on the practical aspects of reentry and the social support factor.

Thresholds' Prison Aftercare Program

Thresholds' prison aftercare program (PAP) is an adaptation of Thresholds' Jail Linkage Project designed to reduce recidivism in prison inmates with severe mental illness (Lurigio *et al.*, 2004). It is based on the assertive community treatment model and focuses on administering individualized, intensive treatment while connecting inmates to community resources and monitoring their postrelease adjustment. One of its main goals is to increase treatment compliance by combating resistance. It is uniquely centered on medication education and management, which is of primary concern in cases of inmates with severe mental illness. Program staff carry small caseloads so they can devote adequate attention and deliver appropriately intensive treatment to each inmate. This includes visiting the participants in their chosen residences and being available to participants for emergency contact 24/7 for the duration of the program (Lurigio *et al.*, 2004).

Prison inmates enter this program through a referral system. Once the program receives the referral, a staff member visits the inmate in prison and conducts a thorough screening as part of the intake process. This screening assesses the inmate's needs through detailed and specific criteria, including psychiatric history, arrest history, and violence risk. Inmates with the most severe histories and low risk of violence to the public are given priority in program enrollment consistent with the risk-need-responsivity model. Similar to CTI, PAP staff focus on discharge planning and forming links to appropriate community resources prior to release. Community treatment providers begin regularly contacting the program participant to conduct their own assessments of the inmate's needs. They also prepare the individual for the demands of the treatment and prepare themselves to meet the inmate's established needs once released. PAP staff then advocate for the inmate's needs to the court so that release conditions may be adjusted to facilitate the treatment plan. At release, a staff member meets the individual at the prison to transport him or her to the planned housing location and helps to meet any immediate physical needs, including moving possessions into the new living space and purchasing groceries. Staff then work closely with the participant, ensuring that he or she is attending treatment appointments, taking prescribed medications, and meeting his or her own physical and psychological needs. Links to community resources are adjusted as necessary. Participants are expected to gain sufficient independence for program termination approximately 12–18 months following prison release. Unique to this program, staff will not sever connections with a participant should he or she be rearrested or hospitalized. Relationships with the client are maintained in hopes of producing long-term change (Lurigio *et al.*, 2004).

An unfortunate reality of such specialized and intensive care is, of course, exorbitant costs. For this reason, PAP must be strict when selecting inmates to participate in the program. Criteria for enrollment include multiple previous involvements in the criminal justice system (including arrests and incarcerations), multiple previous psychiatric hospitalizations, a diagnosis of a severe mental disorder, and a low risk of future violence (Lurigio *et al.*, 2004). It is obvious that inmates who meet these criteria are in dire need of the services the program provides, but many more who would suffer during reentry due to mental illness without some form of additional

help are excluded due to a lack of adequate resources to fund a prisonwide version of PAP for mentally ill inmates. Should funding for such programs increase, it is possible that the resources saved by preventing recidivism could eventually outweigh the costs incurred by implementing intensive treatment like PAP. After all, there is evidence that PAP can be an effective model in multiple respects, including reducing hospitalizations and drug addiction relapse as well as improving housing outcomes (Lurigio *et al.*, 2004).

Ideal Accommodations for Reentry of Mentally Ill Inmates

Although several programs have been created and implemented that target the specific needs of mentally ill inmates following release, reentry programs in general have a long way to go before they can be effective for mentally ill inmates. Considering the additional stressors and difficulties inmates with mental health concerns face during the transitional process, it is necessary for reentry programs to undergo significant restructuring and modification to feature specialized services and treatments that target the unique needs of mentally ill inmates. An ideal program would accomplish this by preparing both the inmates and the communities receiving them through coordination and continuity of mental health care, provision of relevant treatments and trainings, and monitoring of the individual beyond release to facilitate the best possible outcomes. The following sections detail what might be considered a best practices model for the societal reentry of inmates with mental illness based on current research.

Preparing Inmates

Inmates with mental illness should be required to participate in a reentry program. Many of these inmates may not be aware of the availability of a program, may not know how to acquire its services, or may not understand the extent of their need for such a program. Required participation enables the greatest possible reach of the program and ensures that all those who would benefit from the program are able to take advantage of its provisions. Additionally, the program should begin a minimum of 3 months prior to an inmate's release date. Administering adequate treatment takes time and should not be rushed nor shoehorned into the final few weeks of a prison sentence. More time also gives the inmate an increased opportunity to absorb the information, gradually alter behavior as appropriate, and prepare fully for release and reintegration.

The reentry process should include three phases: (1) prerelease assessment, planning, and treatment; (2) continuity of care into the community; and (3) relapse prevention and gradual discharge (Taxman *et al.*, 2003). In the prerelease phase, inmates should receive collaborative, individualized assessment and treatment planning and treatment should be initiated based on this assessment. Early treatment should include detailed information on services available in the inmate's home community for housing, employment, medical care, and mental health care as well as creating links to these community resources (Hopkin *et al.*, 2018). While helping inmates connect to these resources, program staff should also help them contact family members and friends who will be involved in the reintegration process and facilitate healthy interactions with these people to minimize future social isolation and increase social support.

Individualized psychological intervention should include cognitive-behavioral treatment with a positive reinforcement component and should be administered to inmates without severe psychosis to help them gain an understanding of their thoughts, emotions, and behaviors and learn skills with which to modify their behaviors and adopt more adaptive behavior patterns that will help them reintegrate successfully into noninstitutional society. This process should implement psychoeducation related to emotional triggers and behavioral patterns learned during the incarceration period that would prove maladaptive in community living (Rotter *et al.*, 2005). Problem-solving skills training should also be a central component of this phase as a means of discovering solutions to current problems and aiding patients in achieving eventual independence in this regard. Inmates with more severe mental illness, including psychotic disorders, should be treated individually with a focus on medication compliance, achieving basic skills, and psychological stability.

For all reentry program participants, treatment intensiveness should be adjusted for each individual based on level of risk of both recidivism and psychological relapse. Determination of individual needs and level of risk should include assessment of static and dynamic risk factors as targets of treatment (Siwach & Bushway, 2017). Static factors may include criminal history and antisocial personality patterns, while dynamic factors may entail substance use, family problems, and procriminal attitudes (Skeem *et al.*, 2015). Research also suggests that input from individuals regarding their perceptions of their own risk factors is beneficial in treatment planning and reducing recidivism (Morgan *et al.*, 2012b).

In the second phase, where program participants are released into their communities, intensive monitoring must take place to ensure each individual is receiving treatment in the community in accordance with their treatment plan and is maintaining familial and social relationships in a healthy manner. As participants continue to receive treatment, program staff should adjust their linkages as deemed appropriate to optimize adjustment. This modification could include such changes as increasing social support through the addition of treatment groups, incorporating multiple treatment providers for various separate challenges (e.g., substance abuse or

mental illness comorbidity), or recommending temporary hospitalization for participants struggling severely and experiencing psychological decompensation. Although hospitalization is not an ideal result, it is a useful tool to prevent harm until the participant is stabilized.

The goal of the final phase is for participants to achieve a high enough level of self-sufficiency to be terminated from the program. Although program staff continue to offer support through this phase, it is crucial for participants' long-term success that they learn how to function well independently using the skills and resources to which they have formed links through the program. Participants and staff make small adjustments and finalize linkages during this time, and staff become less involved in participants' daily activities. At about 3 months after participants' release dates, ex-inmates should be sufficiently established as members of their communities and comfortable moving forward with treatment autonomously until they achieve complete reintegration.

An important component of any reentry program is assessment. Throughout the program, staff should evaluate participants' progress as well as strengths and challenges. With this knowledge, they can appropriately adjust any aspect of the program to meet each individual's unique needs. Assessment also provides invaluable information on the program itself with regard to the effective or ineffectiveness of its components. The program as a whole should be modified over time to supplement its weaknesses and enhance its strengths.

Substance abuse treatment. Substance abuse and addiction is a unique category of mental illness that further complicates the reentry process for those who struggle with it. For this reason, special attention should be devoted to inmates with addictions and relapse prevention should be a central goal of their treatment plans. In the first phase of the program, there should be a heavy emphasis on psychoeducation regarding alcohol and drugs, especially on their long-term effects on mental and physical health as well as on relationships. Psychoeducation should also focus on changes in tolerance after long periods of abstinence from the substance. Inmates must understand that returning to their ''usual'' dose in an act of relapse can easily result in accidental lethal overdose due to decreased tolerance during their prison stay. Of course, to prevent relapse at all, program staff should take special care to connect participants to drug treatment centers that will target their specific addictions. The specialized treatment and social support network should work together to minimize the potential for relapse.

During the second phase of the program, staff should ensure that participants with substance abuse issues are maintaining healthy familial relationships and receiving adequate support in their attempts to abstain from addictive substances. Social support is paramount in reducing chances of relapse, and many participants will likely feel a sense of accountability when they are close to supportive family members and friends who are helping them in their reintegration efforts. Program staff should facilitate open communication between participants and the inner members of their social circles, especially family, to ensure that these social supports are fully aware of present struggles and can reinforce the participant's goals and connect them to additional treatment as necessary. It is crucial for program staff to examine these social supports for potential threats to successful reintegration, especially when family members and/or friends are involved in the criminal justice system themselves and/or abuse substances. In these cases, it may be necessary and conducive to a successful reentry process for staff to help the inmate establish new social support systems through such avenues as therapy groups and addiction support groups and closely monitor contact with the potentially problematic supports.

By the final phase, participants should be achieving a firm grasp on their individual needs in terms of treatment and relapse prevention and should be practicing coping skills learned in treatment to deal with urges to return to their addictive substances of choice. Social support should be steady and based on healthy, well-maintained relationships with family and friends. Program staff should be able to take gradual steps back from the participants to allow them to become increasingly independent until discharge from the program is appropriate.

Suicide prevention. With suicide being of central concern in mentally ill populations, suicide assessment and prevention should be a consistent emphasis of any prison reentry program for inmates with mental illness. An initial suicide assessment upon a participant's entry into the program should inform treatment planning. If a participant shows signs of suicidal ideation, plan, or intent, he or she should be monitored frequently for changes in any of these cognitions. Participants displaying potential suicidality may be good candidates for hospitalization immediately following release. With treatment to achieve stability and decrease suicidality, the ultimate goal should be to release participants into their communities to receive ongoing treatment in a noninstitutional environment.

Program staff should connect all participants with multiple resources that combat suicidality. Participants must have the phone number of a suicide hotline and should understand that this number can and should be called at any time when experiencing suicidal ideation. Ideally, if program staff have small caseloads, they should follow the PAP example by allowing 24/7 contact during the second phase of the reentry program only. Participants may be more willing to talk about such a sensitive issue with someone they know than with a stranger on the phone. Additionally, participants should be taught

to self-monitor for any indications that they are becoming a danger to themselves. Program staff must also encourage participants to contact any of the provided resources, which may include suicide hotlines, treatment providers, or family members, as soon as they recognize signs of suicidality.

Preparing Communities

Preparing prison inmates for reentry is crucial to their success. However, preparing the communities that will receive them is just as important for facilitating a smooth transition process. Perhaps the most essential key to creating an optimal experience for program participants is full collaboration between the criminal justice system and community service providers (Vogel *et al.*, 2007). Simply making referrals for participants to community resources that may or may not be willing to treat them is not sufficient to ensure continuity of care. Service providers in the community must be willing to work together with program staff to develop systems of treatment that will initiate while participants are still incarcerated, resume in the community immediately upon participants' releases, and continue beyond the duration of the reentry program. To accomplish this, program staff will need to seek out community treatment providers who are willing to work with former inmates and will form a contract with the program. Ideally, the program will be able to contract with multiple providers who will treat comorbid disorders, psychotic disorders, substance use disorders, and any other mental illness conditions present. They should be involved in the initial assessment and treatment planning process to ensure that the plans will still be executable under their services independent of the reentry program. To prepare community providers who do not have prior experience working with prison inmates, cultural competency training focused on incarceration-specific learned behavioral patterns can prove crucial in alleviating the shock of encountering patient behaviors otherwise considered unusual and/or problematic in a community setting and prevent damage to therapeutic relationships should these behaviors occur (Rotter *et al.*, 2005).

Preparing communities to receive prison inmates also includes working directly with inmates' families and close friends if possible, as postrelease familial support is directly related to positive mental health outcomes for prison releasees (Wallace *et al.*, 2016). The reentry program should involve family members in all three phases of the program. Helping families connect with inmates prior to release and maintain relationships after release will be beneficial to both parties in that they will understand what to expect from the reentry process and will be able to prepare collaboratively for the challenges they will face. Psychoeducation is invaluable for families. They must learn about the inmate's psychopathology and how it affects him or her, the process of deinstitutionalization and the specific challenges it is likely to present, and the resources available to help with reintegration difficulties.

Suicide prevention. Although most of suicide prevention takes place with the program participants themselves, communities must also be prepared to take action should the need arise. As program staff assess for suicide during the first phase of the program, they should report results of these assessments to the community treatment providers to which they have connected participants for postrelease treatment. This could include treatment centers, therapists, or psychiatric hospitals. The providers can then target suicidal ideation as a treatment priority as soon as the participants enter the community. If program staff have reason to believe that a participant may act upon suicidal thoughts, the participant should be placed in a hospital after release until he or she is stable enough to live in a noninstitutional environment with more limited monitoring by treatment providers. Regardless of postrelease placement, all participants who demonstrated suicidal ideation, plan, or intent at any time should be continually assessed while in the community.

Families should also be equipped to react appropriately to potential suicidality. Program staff must educate families on the signs of suicidality and instruct them to take any statements about self-harm seriously. Psychoeducation should also include specific information on the myths and facts of suicide as well as appropriate ways to react to an actively suicidal person. Along with participants, families should have access to resources in case of an emergency of this kind so they can contact a professional for immediate intervention.

Conclusion

Prison reentry programs in general have a long way to go before they can be considered even adequate in preparing inmates for the challenges of reintegration and reducing recidivism. Research has demonstrated the extreme difficulties ex-prisoners face after release with regards to housing, employment, and medical care, among many other living necessities, as well as the high rates of failure to achieve adequate reintegration as evidenced by high recidivism rates, health problems, and mortality. Mentally ill inmates experience all these problems in addition to their daily struggles to cope with psychopathology and obtain effective mental health treatment after release from prison. These compounded difficulties require highly specialized, collaborative treatment from prison staff and community treatment providers for successful transition into the community to be effective. Unfortunately, reentry programs that truly meet the transitional needs of mentally ill people are extremely rare due to many logistical barriers, including funding, resource availability, and community

reluctance to treat them. However, several programs have been developed that work around these challenges and have demonstrated initial success in facilitating the reentry process and reducing recidivism for mentally ill inmates. Perhaps with time, alterations to funding, and further research on the effectiveness of such programs, more specialized reentry programs for prison inmates with mental illness can be developed and implemented nationally and internationally. After all, helping ex-prisoners reestablish themselves as contributors to their communities and reducing recidivism benefits the inmates themselves as well as society in general.

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