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Engagement Processes in Model Programs for Community Reentry from Prison for People with Serious Mental Illness

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Abstract

Linking prisoners with mental illness with treatment following release is critical to preventing recidivism, but little research exists to inform efforts to engage them effectively. This presentation compares the engagement process in two model programs, each representing an evidence-based practice for mental health which has been adapted to the context of prison reentry. One model, Forensic Assertive Community Treatment (FACT), emphasizes a long-term wrap-around approach that seeks to maximize continuity of care by concentrating all services within one interdisciplinary team; the other, Critical Time Intervention (CTI), is a time-limited intervention that promotes linkages to outside services and bolsters natural support systems. To compare engagement practices, we analyze data from two qualitative studies, each conducted in a newly developed treatment program serving prisoners with mental illness being discharged from prisons to urban communities. Findings show that the working relationship in reentry services exhibits unique features and is furthered in both programs by the use of practitioner strategies of engagement, including tangible assistance, methods of interacting with consumers, and encouragement of service use via third parties such as families and parole officers. Nevertheless, each program exhibited distinct cultures and rituals of reentry that were associated with fundamental differences in philosophy and differences in resources available to each program.

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Keywords

prisoners; reentry; FACT; CTI; engagement models

1. Introduction

Studies show that as many as 16% of prison inmates meet criteria for a serious mental illness (Ditton, 1999). Recognition of the overrepresentation of people with serious mental illness in the criminal justice system has led to the development of specialty services for prisoners with mental illness, both within prisons and jails (Hills, Siegfried, & Ickowitz, 2004) and within community settings (Steadman, Morris, & Dennis, 1995; Wilson & Draine, 2006). Intervening at the point of transition from jail or prison to community, commonly referred to as community re-entry, is considered a prime opportunity for halting the cycle of reincarceration (Petersilia, 2003).

Reentry from prison is known to be an especially vulnerable transition for all offenders, not merely for those with mental illness. As Draine, Wolff, Jacoby, Hartwell and Duclos (2005) detail, offenders typically exit prison with painfully few financial or social support resources to enable them to adjust successfully to community life. The situation is further compounded by the fact that former prisoners return disproportionately to destitute communities which possess inadequate resources to meet the needs of their own residents, much less the inflow of offenders (Clear, 2007).

As a result, the transition from prison to community poses great risk to offender health and safety. In a landmark study, Binswanger and colleagues (2007) demonstrated that, adjusting for sociodemographic factors, the risk of death (primarily from suicide, homicide, cardiovascular events, and drug overdose) rises thirteen fold in the two weeks following release from prison. Lacking homes to return to, many former prisoners often turn to shelters and other congregate environments with inadequate sanitation, compounding their health risk. Immediate tasks of securing a place to live, making contact with parole authorities, finding a job, and/or applying for financial benefits are all necessary to ensure survival, yet a felony record represents a serious disadvantage to accomplishing these tasks. As Binswanger et al. (2011) found in a qualitative study of newly released offenders, the formidable tasks of transition coupled with the disadvantage associated with a criminal record may lead to demoralization, fear, and anxiety. For offenders with mental illness, who lack connection to a mental health service provider following the transition, the risk of suicide, reincarceration, and/or hospitalization may be even higher than that of their counterparts who do not have mental illness.

For all of the above reasons, connecting people with mental illness to mental health treatment and other support services during the transition out of prison is deemed critical to reducing the risk of negative outcomes. Engaging them in these services, however, is a major challenge. Prisoners treated for psychiatric disorders are often released with only a very limited supply of medication, which runs out before connection to mental health services is assured (Binswanger et al., 2011). Such connections, when they are made, must be negotiated by the former prisoner, who may lack the necessary information, access, and

health insurance in the early period following release. Even when resources are available, they may be concerned about using them: studies of prisoners' attitudes toward mental health treatment suggest that fear of formal labeling, concerns about stigma, and distrust of authorities are major barriers to service engagement (Howerton et al., 2007; Kenemore & Roldan, 2006). Thus, programs which serve people with serious mental illness during the high risk reentry period must incorporate strategies of service engagement to remove barriers and build motivation to participate in treatment. Little research has been conducted, however, to guide programs in effective engagement practices. This qualitative study of two reentry programs serving adults with serious mental illness leaving prison examines engagement processes across two reentry models in an effort to build knowledge regarding effective engagement.

1.1. Concept of Engagement

Engagement in mental health care is a phrase commonly invoked to refer to a variety of attitudinal and behavioral phenomena related to involvement in mental health services (Staudt, 2007; Littell, Alexander, & Reynolds, 2001). In the narrowest sense, researchers use the term "disengagement" to denote dropping out of, or demonstrating poor attendance to, treatment (Kreyenbuhl, Nossel, & Dixon, 2009). Dropping out of treatment is thought to be an especially negative outcome for people with mental illness because it not infrequently leads to medication discontinuation, and readmission to institutions such as hospitals, jails, and prisons (Kreyenbuhl et al., 2009). When engagement is equated with treatment attendance and continuance, the task of the engagement process is to motivate the client to continue to attend treatment and to resolve environmental barriers to participation.

In other studies and literatures, engagement carries a broader meaning encompassing not only behavioral participation, but also affective and cognitive elements (Gopalan, Goldstein, Klingenstein, Sicher, & McKay, 2010). As Littell, Alexander, and Reynolds (2001) discuss, participation in services may be viewed as a 2×2 typology in which both activity level and valence are considered. Those with higher activity (e.g., attendance, participation) and positive valence (cooperative attitude) are considered "engaged", whereas service providers tend to regard clients exhibiting a pattern of cooperative behavior but little investment in the work of treatment as "acquiescent" or passive participants. Clients with a less cooperative attitude are seen as either "disruptive" or "disengaged," depending upon how active they are in opposing treatment goals. Their conceptualization points to the importance of considering engagement as not simply attendance, but also the degree to which the client is invested in the work of treatment and the pursuit of treatment goals.

Broader conceptions of engagement also shift focus from the intrapersonal to the interpersonal realm, in that engagement is not simply a reflection of the client's attitudes and efforts, but also of his or her interactions with service providers. Stanhope (2012), for example, describes that engagement is "a process made up of multiple events...[and] is shaped as much by the quality of interaction between providers and service users as it is by the specifics of the service provision." (p. 414). To be successful in engaging clients, programs must not only induce clients to attend or "show up," but also to get their "buy in" (Yatchmenoff, 2005) by inviting them to collaborate in the work of treatment and recovery.

In the context of community reentry from prison, the key tasks of treatment are not limited narrowly to amelioration of mental health symptoms, but must also include engaging clients in the work of “making good”: developing new identities, restoring or recreating connection to the social structure, and desisting from crime (Maruna, 2001).

Hence, while engagement is often measured by examining either the attitudes or behaviors of the client, practitioners play a pivotal yet underappreciated role in the engagement process (Staudt, 2007). Engagement strategies are those activities undertaken by programs and providers aimed at fostering client participation and investment in both treatment and the pursuit of life goals. Within the field of mental health services, engagement strategies may be divided into those activities aimed at maximizing the possibility of entering treatment and/or returning after the first visit (initial engagement); and those activities which aim to increase continued participation or compliance with treatment regimens or plans (ongoing engagement) (McKay, Stoewe, McCadam, & Gonzales, 1998). Roter et al. (1998) classify the various strategies of promoting compliance as being behavioral, educational, or relational (or a combination) in nature.

Behavioral strategies include reminder letters or phone calls to increase attendance at appointments, providing praise or tangible rewards when attendance or participation goals are met, and even providing financial incentives for attending treatment or taking medication (Priebe et al., 2010). Initiatives to remove access barriers by providing transportation, allowing scheduling flexibility, or arranging child care could likewise be seen as behavioral or task oriented in nature. Educational strategies are exemplified in psychoeducation programs which aim to teach consumers about the symptoms of mental illness, to help them to identify their personal warning signs of relapse, and to reinforce the connection between adherence and preventing relapse (Kelly & Scott, 1990).

Relational strategies seek to further participation by creating or reinforcing a bond between clients and service providers or programs, drawing upon literature suggesting that a strong therapeutic alliance is associated with more consistent treatment participation (Marsh, Angell, Andrews, & Curry, 2012). McKay and colleagues (1996, 1998) undertook a unique relational approach to initial engagement by telephoning clients prior to the first scheduled appointment to discuss and resolve barriers to participation and open lines of communication between providers and clients, reducing client hesitancy to ask questions and clarify information about the treatment process. The recent movement to incorporate shared decision making into mental health practice likewise reflects the importance of collaborative relationship building to foster engagement (Drake, Deegan, & Rapp, 2010).

Recent research suggest that relational strategies are uniquely important in the engagement of clients with serious mental illness who have multiple system involvement or are making a high risk transition. Stanhope (2012) used an ethnographic research design to study the engagement process in one particular model of service delivery for people with serious mental illness making the transition out of chronic homelessness. The model, Housing First, is unique in its provision of housing as a guaranteed resource at program entry. As Stanhope describes, the provision of the housing catalyzes engagement of clients because it signifies that the service provider has made good on his or her word, thereby creating a bond of trust.

As service delivery proceeds, concrete, everyday acts of shopping, home visiting, and errand-running further cement the treatment bond because they provide a window into the clients' personalities, needs, and desires on the part of the service provider and create for the client a sense that they are seen and known – experiences that they have little access to in their former lives as homeless people living on the street. Case managers also promoted an egalitarian tone to the treatment relationship by meeting with people in everyday environments and eschewing typical prohibitions of familiarity and intimacy. For example, case managers hugged their clients, permitted clients to create nicknames for them, and took crisis calls from clients during non-work hours. In a similar way, Chase, Zinkin, Costall, Watts and Priebe (2010) and Ware, Hopper, Tugenberg, Dickey, & Fisher, (2007) describe the importance of the non-hierarchical, quasi-friendship quality of therapeutic relationships in psychiatry promote clients' sense of agency and personhood, pointing to the importance of relaxing traditional therapeutic strictures to promote engagement.

While a substantial research base suggests that the fundamental element of the therapeutic relationship is a trusting bond in which both parties agree upon the basic goals and tasks of the therapy, recent research suggests that the alliance exhibits distinctive complexity in services at the nexus of mental health and criminal justice. Skeem and Eno Louden (2007), for example, highlight the need for specialty probation officers to attend to the dual-role aspect of their relationships with probationers; that is, they hold power over the probationer yet at the same time must work to engender trust in order for problem-solving activities to proceed and in order to avoid the probationer responding to the officer's power with defiance or negativity. As Liebling, Price, and Elliot (1999) describe with respect to prison officers, relationship building in a coercive context requires that power be "held in reserve," invoked only when necessary for maintaining safety. Clearly, the roles and tasks of mental health workers working with justice-involved consumers are very different from those of correctional officers, yet they are similar in the sense that mental health staff act to foster social integration and function at the same time that they also perform social control functions (Pescosolido, Wright, & Sullivan, 1995). In this sense, providers operating in the mental health-criminal justice interface must approach engagement with great sensitivity regarding power dynamics in order to build trusting relationships that motivate treatment participation.

1.2. Current Study Focus

In the current study, we examine the engagement process in two programs designed for prisoners with mental illness in the process of reentry into the community: Critical Time Intervention (CTI) and Forensic Assertive Community Treatment (FACT). Each program represents an adaptation of an existing evidence-based treatment for people with serious mental illness to the context of prison reentry, and attempts to address the issue of the overrepresentation of people with mental illness in jails, prisons, and correctional supervision (Morrissey, Meyer, & Cuddeback, 2007; Draine & Herman, 2007; Wolff et al., 2012). Critical Time Intervention was developed as an intervention to smooth the transition to the community from an institution, such as a homeless shelter or hospital (Draine & Herman, 2007). It consists of time-limited (9 month) case management services which adopt a distinctive focus of helping the client build community connections. Central to the

intervention is the transitional focus, in which the case manager is deliberate in helping the client build linkages to treatment programs (psychiatrists, therapists, housing programs, day treatment) and community connections (families, landlords, social networks). While the case manager also advocates for the client directly and uses motivational and problem-solving strategies to assist the client in meeting his or her goals, the focus of the work is to aid the transition to other, more durable sources of support.

Forensic Assertive Community Treatment represents an adaptation of an existing evidence-based treatment, Assertive Community Treatment (ACT), to the context of co-occurring criminal justice involvement. ACT is a model of case management in which a multi-disciplinary team provides comprehensive supports to the person with mental illness in an individually tailored manner. Unlike the CTI model, it is explicitly a time-unlimited intervention which presupposes the need for ongoing support that may be titrated to current levels of need as the individual copes with a chronic disorder. As Cuddeback, Morrissey, Cusack, & Meyer (2009) discussed, FACT is typically modified in several ways from the original ACT model: the focus of the team's efforts shifts to preventing incarceration rather than hospitalization; there is more direct collaboration with criminal justice authorities; and often, the implicit threat of reincarceration is used as leverage to promote compliance with treatment. In the FACT program featured in this study, however, the nature of collaboration with criminal justice was informal (i.e. no criminal justice professionals served on the FACT team).

Despite significant differences in the philosophy of the CTI and FACT models, they share a focus on pragmatic, concrete intervention, problem-solving approaches, and in-vivo service provision. The aim of the analysis presented here is to describe how engagement of clients in treatment and the goals and activities of treatment is accomplished and to identify similarities and differences in approaches to engagement between the CTI and FACT programs.

2. Methods

2.1. Sample and Design

Data from the FACT program were collected as part of an evaluation which commenced at the program's inception in 2007 in Chicago, IL. Inmates identified as special needs prisoners within the Illinois state prison system were referred to the program as their release date approached. The clinical supervisor for the program reviewed the prisoner's mental health record to determine eligibility (Axis I diagnosis of schizophrenia, bipolar disorder, or depression and a Chicago residence) and if the prisoner consented to enter the program, their reentry planning was conducted by the FACT program. Once established in the community, participants were approached for participation in the evaluation. All individuals approached for participation consented to be in the study (n=21), but one participant was unable to complete the study because of severe psychiatric symptoms. Of the 20 remaining participants, 19 consented to participate in the qualitative component of the evaluation, which took place over 18 months. This component entailed 9 months of contact with an assigned ethnographer who conducted 2 semi-structured interviews and a series of 5–10 "go-along" interviews (Garcia, Eisenberg, Frerich, Lechner & Lust, 2012) in which the

ethnographer participated in everyday activities with the respondent, over a 9–12 month period. For the go-along interviews, data were gathered in the form of field notes. Staff of the program (n=5, including the clinical supervisor, three case managers, and a vocational specialist) were interviewed 1–2 times using an audiotaped semi-structured interview protocol. Finally, ethnographers attended regular weekly team meetings in which cases were discussed and gathered information via field notes.

Data for the CTI evaluation were gathered as part of a sub-study of program fidelity within a larger randomized controlled trial of CTI vs. enhanced reentry planning, conducted in Camden County, NJ. Special needs prisoners were identified by prison staff and referred to the research coordinator, who screened potential participants for eligibility (mental illness and a Camden County residence). Participants (n = 216) who consented to take part were surveyed while in prison and followed for 18 months post-release. For the fidelity component, which was conducted two years following the program inception, two qualitative interviewers (first and second author) worked with the research coordinator to select 18 participants for the CTI group only to take part in a semi-structured qualitative interview regarding their experiences as a participant in the program. In addition, program staff (n=6) participated in a qualitative interview.

Interview questions in each study covered a variety of domains; of relevance to the present analysis were questions which inquired about client experiences of entering the program and interacting with staff; and staff accounts of how they worked to engage clients in taking part in the program and in the work of reentry.

2.1.2. Analysis—The analysis presented here is based on analysis of interview data with staff and consumers of both programs (a total of 68 interviews with 44 participants). Coding and analysis were conducted primarily by the first author, who coordinated and participated directly in data collection in both studies; and the second author, who was not involved in data collection; with input from the third author, who gathered data in both studies. Analysis was conducted using constant comparative analysis, a style of coding data frequently associated with grounded theory. Grounded theory was first developed in the 1960's by sociologists Anselm Strauss and Barney Glaser, and has been further developed and interpreted by students and trainees of the method's founders such that the method is viewed today as a family of related methods rather than a unitary set of procedures (see LaRossa, 2005 for a historical treatment of grounded theory). At the heart of the method is a reverence for developing theoretical explanations for social phenomenon inductively from data rather than deductive testing of previously existing theory. The method is therefore ideally suited for generating new substantive and theoretical insights into areas in which little is known, or to provide new theoretical insight into existing domains of study. Although technically atheoretical, grounded theory is said to proceed from a symbolic interactionist or social constructionist framework in the sense that there is a concerted effort to base theoretical observations on the social meanings – both individual and collective – ascribed to situations by the actors who take part in those situations. In addition, all variations use an overall style of coding qualitative material that is commonly referred to as constant comparative analysis, in which concepts are derived by linking indicators to conceptual labels, which are

subsequently refined by comparison of each new case or instance to the existing set of categories to further refine them and allow all instances to be subsumed within them.

Although there is great heterogeneity in grounded theory procedures, analysis of data (whether it takes the form of interview texts, field notes, documents, etc.) tends to proceed in several phases, described below. In this study, the analysts (first and second authors) proceeded by reading each transcript independently to identify areas of the transcribed interview texts pertained to either the nature of engagement or the process by which it occurred. Second, the analysts divided the selected materials and conducted open coding by going through the text line by line, and summarizing both the main storyline and specific dimensions of engagement from each case in the form of analytic memos. Then, the analysis exchanged memos and compared instances of similar concepts across interviews to derive consensus on key phenomena represented in the data. Using a process of comparison of each new instance or case with the previously developed categories, the analyst refines the categories to create dimensions (referred by some as “variables”, LaRossa, 2005) which vary across cases. From these memos, the analysts worked together as a team to merge the large number of categories identified into more abstract higher order concepts. For example, an instance in which a consumer reported being impressed that his case manager was willing to sit on the floor in his apartment as an example of a category we designated as “leveling,” in which the provider engages in behavior that lowers the hierarchy between provider and client. This category, in turn, was further subsumed under a higher order category we designated as “engagement manner,” referring to ways in which providers acted strategically to develop a bond of engagement with their clients. In the next phase of analysis, axial coding, involved analyzing a single concept in terms of its related subconcepts and to assess the process (e.g., phenomenon X occurs under conditions of Y, with consequences of Z) by comparing and contrasting cases and instances. For example, cases where staff or clients described successful engagement were compared with ones in which engagement was less successful; and the context of each case was examined to assess factors such as monetary resources and the presence or absence of a parole order to determine contextual factors which appeared to promote or inhibit engagement. Finally, the process of selective coding involved interpretive work to develop the “storyline” of the analysis as a whole and the core categories which form the backbone of the storyline (in this case, engagement strategies used by providers and the resulting relationship bond, which together comprised the engagement process). In this phase, input from the third, fourth, and fifth authors was sought and incorporated into the final theoretical framework.

In interpretive methods such as grounded theory, a variety of procedures may be followed to foster rigor and trustworthiness, though they typically differ from procedures used in quantitative research (Williams & Morrow, 2009). One key focus of concern in these efforts is guarding against the investigator imposing a pre-existing perspective upon the data. The team-based approach used in this study was one safeguard against this problem because the investigators brought different experiences and perspectives to the analysis, with some having a background in mental health treatment, others having a background in criminal justice, and with several members having experience providing services in programs similar to those we studied. In addition, some of the analytic team (B.A., S.B., A.W., J.D.) contributed direct knowledge of the field sites and participants to the analytic process

whereas the fifth member (E.M.), who had no direct knowledge of the field sites, was able to bring a “clean slate” without presuppositions about the meaning of events described by participants. As is typically the case in interpretive methods relying on induction, coding decisions were reached by consensus rather than checked for inter-rater reliability, as would be the case had the team been working with a pre-developed codebook, as is done in other types of qualitative approaches (see, for example, Miles & Huberman, 1994).

Triangulating data from multiple sources, as we did by having our research team conduct observations as well as gather data via interviews, helps to minimize the reliance on self-reported data, which may be affected by social desirability concerns, by providing a third party observer perspective. Immersion in the settings in which reentry services took place over many months also served to deepen the analysis by grounding the categories in a social context and ensuring that we did not simply capture a “snapshot” that might inadequately reflect unfolding social processes.

3. Results

A conceptual map of the major analytic categories is given in Figure 1. Central to the engagement process was the development of a relationship bond between the staff and consumers of each program, which was a necessary element to both 1) promoting consumer investment in the shared tasks of treatment and 2) enabling the staff to provide client-centered care and to invest themselves in that care. To develop the relationship bond and to promote mutual investment in the recovery process, staff in both teams used a variety of engagement strategies.

3.1. Relationship Bond

Staff from both programs saw the development of a relationship bond with the consumer as essential to program engagement, and as such, they were deliberate in their efforts to create and sustain this connection. Client provider relationships are commonly viewed as important in mental health treatment, as well as in other human service domains (Marsh et al., 2012). As illustrated by both teams, however, bonding in the context of reentry to the community from prison exhibited several unique features which distinguish this relationship from the prototypical therapy relationship. While all therapeutic relationships necessarily involve trust between client and provider, trust was considered especially pivotal in reentry relationships because the consumers experienced the ability to trust staff as a significant departure from their past interactions with authorities, which were often coercive in nature. From the consumer standpoint, this sense of trust was often described as a sense of surprise that staff members actually delivered on the help they promised, which in turn engendered closeness and familiarity. As one CTI consumer stated regarding her case manager:

I don't even look at her as a case worker no more. I look at her as one of me...and that makes the bond, the friendship closer together 'cause it's like I don't just look at her as just my case worker 'cause she actually helps. If I call her...and it got something to do with mental health or anything like she actually do her job and she'll jump on the phone.

Solidified trust developed through providers delivering on help promised also increased consumers' confidence that they could tell the case manager about risky or illegal activities without fear of being judged or reported to the authorities. Using a phrase echoed by several participants, one CTI participant stated, he could "*keep it real*" with his case manager and when asked to discuss how he had decided the case manager was trustworthy, explained that she had "*represented*" him when he got out of prison by arranging for him to stay in a hotel until he had arranged a more permanent place to live. In a similar way, consumers who did not develop trust in their providers, or developed this trust more slowly, explained that they felt wary about the case manager's motives or potential actions. One of the respondents from the FACT program, for example, reported to her study interviewer that she concealed the fact of having applied for disability benefits from her case managers out of a sense of wariness that the staff members would remove the income from her control. In order to avoid disclosing such important details, she sought to accept only the help she felt was absolutely necessary from the team for fear that accepting support obligated her to a reciprocal bond of trust. Explaining to the study interviewer her wariness when the FACT staff would approach her for contact, she explained that she kept them at arm's length: "*That's all they do is pay my rent. I don't ask 'em for nothin'.*" The clinical supervisor, in her interview, described this client's behavior as follows:

She – she – really, from the beginning, I mean, she was really kind of hard to reach. And she does her own thing, and she is very selective about what she shares with any of us...we're – we're really rarely seeing her at all...she never opens the door for us...doesn't really keep her appointments with us. So I just – she's really kind of out there on a limb, and I don't really know what's going on with her.

A second important feature of consumer-staff reentry relationships is a reduced perception of hierarchy between consumers and staff, or "leveling" of the professional relationship. This leveling was accomplished by relaxing many of the boundaries and strictures characteristic of client-provider relationships, such as proscriptions against self disclosure. Staff would often accept phone calls from consumers on their cell phones after hours, and generally adopted a casual and friendly manner in their interactions with clients. As discussed in relation to trust, leveling the relationship conveyed a message to consumers that this was a "real" relationship, not simply a bureaucratic one. As one CTI participant stated, he perceived that his case manager approached him differently than had other providers from his very first meeting with her in the prison. As he put it, when the case manager discussed the program with him during their first meeting, "*She was like really...talking to me. Wasn't like...trying to sell me something...for once somebody ain't just trying to sell me something just to get paid.*"

As implied in the foregoing quote, the relationship bond in reentry case management relationship was also distinctive in its conveyance to consumers that case managers' efforts and emotional investment in consumers' success transcended the expectations of the job role, a perception expressed by many as the job being seen by the case manager as "more than a paycheck." Consumers expressed that when they believed that their case managers were going above and beyond job expectations, this granted a sense of solidarity and inspired them to work toward their own goals. From the case manager's viewpoint,

believing that their service efforts transcended basic job expectations gave a difficult and meagerly compensated job special meaning. As one CTI case manager stated, *“It’s one thing to do it as a job because you get paid for it, but it’s another thing to do it from the heart because you really care.”*

3.2. Pre-Release Engagement Strategies

In both programs, staff endeavored to establish an initial working relationship with the consumer prior to release from prison by visiting them and discussing the goals and methods of the program. If the time between the initial meeting and release was longer than a few weeks, the staff of the program often visited the consumer again (several times if necessary) or communicated with them via videoconference. This initial engagement process accomplished the important function of ensuring that the offender would remember the program’s identity upon release, which was particularly important in the CTI program, because the staff of the program relied on the offender to contact the program upon return to the community. In the FACT program, staff typically transported the offender from the prison to prearranged housing. Developing a connection with the offender prior to release was nonetheless important because it created an expectation on the part of the prospective client that the program would be a reliable source of emotional and practical support upon release. In describing the program offerings to the prospective client, staff were careful to “sell” the program by extolling its benefits while at the same time being careful not to promise assistance that they could not actually provide. This was especially important in the CTI program because they had little to offer in terms of financial assistance and consequently, could not offer housing. As one case manager put it, *“I always make sure that I am very clear and direct about the services we can provide so that the clients don’t have the wrong intentions and think that we’re going to be able to put them in a house as soon as they get out...”*

Because the reentry procedure in the CTI program was vulnerable to loss of prospective clients following release, that program’s staff took special care to gather contact information for relatives and other members of the offender’s social network prior to release. Two case managers reported, in addition, that if they possessed contact information for the family or network member whose home the offender had indicated was his or her intended residence, the case manager would call the network contact a couple of weeks prior to release to introduce herself and notify the collateral of the projected date of release. One consumer, quoted below, described his case manager’s tenacious effort to contact him through his sister as the key reason he engaged with the program a few days following his release from prison:

What’s the first thing I did?...Got my eat on. Then my sister called. She came and picked me up. I spent time with her and went to see my Mom. I tried to get in contact with my ex-wife. And then like an hour later my cousin called and she was like, ‘There’s a lady. She keeps calling.’ I said, ‘Who?’ She’s like ‘Miss [Case Manager name].’ I said, ‘Oh, that’s the lady from [agency name]. What’d she say?’ ‘She said give her a call.’ But I didn’t give her a call. I went to parole. [Describes two unsuccessful attempts to get assistance financing housing from parole] When I left my cousin, she said, ‘Miss [CM name], she keeps calling you.’ So I gave her a call and we met up.

Following this description, the consumer narrated that the case manager had telephoned a parole officer on his behalf, and after being denied assistance, contacted a parole supervisor and ultimately was successful in persuading parole to subsidize temporary housing for the consumer. The example points out several important features of the engagement process. One is that reconnection to informal networks is the priority of newly released offenders, as opposed to service use. This means that engagement efforts will be buttressed by coordination of efforts with primary network members. Secondly, the example points out the importance of aligning service availability with need: that is, the engagement process was catalyzed by the case manager offering help and support at a critical juncture in which the client recognized that his own resources were insufficient to meet critical needs. The case manager's ability to deliver on assistance created a bond of trust that opened opportunities for the client to derive other benefits from taking part in the program.

3.3. Reentry Engagement Strategies

Once the staff of each program had made contact with the offender upon release, the individual became a "client" or "member" of the program. The activities of the program then shift from efforts to locate the client to helping them to secure basic needs: housing, welfare or disability benefits, state identification, and – in some cases, paid work. In the midst of these activities, staff members continue to work toward engaging clients, both as a means of motivating them to remain in contact with the program and also to encourage their participation in enacting treatment goals, such as drug abstinence, maintaining their housing, and forming and reactivating social connections. In this analysis, we categorize the programs' methods as engagement activities, engagement manner, and third party engagement.

3.3.1 Engagement Activities—As noted above, reentry programs work with clients to accomplish a variety of concrete tasks during the first weeks following release, because clients often leave prison with little more than the clothes with which they arrived. The FACT program exhibits a distinct approach in that their initial funding source, a grant from a local foundation, established a revolving loan fund which the program used to establish clients in housing placements and procure essentials (food, clothing, supplies) immediately upon release. This revolving fund functioned as a safety net during the significant lag time between application and acceptance of a welfare or disability benefit claim. This lag time was compounded by common roadblocks to even applying for disability benefits and food stamps, such as the bureaucratic labyrinth surrounding the process of obtaining state identification after release from jail or prison (see Wilson, 2009). Thus consumers in both programs often waited months, or even longer, as they moved along the process of benefit application and, in some cases, appeal and reapplication; as one consumer in the CTI program put it, *"it's like fighting your way through a paper bag and you don't get nowhere."* During this frustrating waiting period, the loan of rent payments and money for food and basic supplies was an invaluable resource.

In the context of FACT, receiving these tangible goods was a welcome surprise to clients, many of who had previous experiences leaving prison without such extensive support. Thus, although there was an explicit expectation that clients would repay the program for the funds

loaned prior to receipt of benefits, clients received the tangible goods provided by the team as ‘gifts’ of support. One FACT consumer described how deep an impression these initial supports made on him:

You know, it’s not easy for some guys to make the transition from penitentiary to permanent placement, cause you’re not ready for it. With [FACT], you have to be ready for it, pretty much. Your mental state has to be ready to absorb the shock of, like, wow, you know, all this – all this is for free? You know, I still have to wake up some mornings, like, man, I’ve got somebody paying my rent, somebody bringing me food, giving me money for food. Somebody’s making sure I get clothes, you know? And this is all for free, until you can get on your feet...Don’t get it mixed up, it’s not a forever situation. This is just something to help you ‘til you get on your feet...I just want to say it’s unbelievable that there are people out there that care that much about other – other people in society who you would like to call throwaways. You know, yeah, when you – when you’re in penitentiary, you feel like a throwaway. Somebody just cast you aside and say, “Hey, you don’t count.” But [FACT] makes you feel different about yourself.

In addition, the activities associated with buying supplies and applying for benefits served as a vehicle for clients and staff to get to know each other, develop a friendly rapport, and to provide opportunities for the client to view the case manager as helpful and available, securing trust.

There was no resource comparable to the revolving fund in the CTI program, but case managers were nevertheless resourceful in tapping service provider networks to obtain goods for their clients. Typically, clients would live with a relative or romantic partner, but those who did not have a social network member to take them in would receive a short term (two weeks) housing voucher from the team that would enable them to stay in a motel room. At the time this study was conducted, New Jersey provided general assistance benefits to men who met a minimum income threshold, but withheld this benefit from individuals with a drug distribution charge on their criminal records. Investigating the offender’s record and history was therefore an important first step staff took even prior to release so that they could anticipate the types of support they would be able to help arrange. For example, the primary homeless shelter in Camden required welfare eligibility, which was off limits to felony drug offenders. For those clients, the staff would dedicate special effort to helping the client apply for jobs as a way to meet basic subsistence needs.

Provision of assistance and resource represented a critical mechanism for engaging clients in both program, for several reasons. First, case managers found that accompanying their clients on these activities provided a vehicle for seeing the client regularly, making it possible to develop a working relationship with him or her. As one CTI staff member stated, helping the client apply for welfare benefits was *“usually a bonding experience because you’re there for hours”* and went on to describe the many places she was likely to take clients in the initial weeks after program entry. She then added: *“Even if they have transportation, I’ll offer to take them just so that I can be there to support them and we can spend a little bit of time together, get to know each other a little bit better.”*

A second function of accompanying or transporting clients to obtain basic needs was that it demonstrated to clients that the program was a helpful resource and that the case managers could be relied upon to deliver on help promised. In the FACT program, being able to make goods and services appear – seemingly out of thin air – created a gift-giving dynamic in which the client felt indebted to the program for support. In the CTI program, a similar dynamic was created because the staff responded to the clients' desperation through intense efforts to advocate for benefits and services for the client, such as free medications, housing vouchers, and job applications. Several respondents referred implicitly to the importance of the case manager's social capital (knowledge, connections) when they would say that what made a difference was that the case manager "represented" them to the bureaucratic authorities: as one of them put it, it was important that the authorities "*see I have somebody representing me.*" This dynamic promoted the clients' perceptions of the staff members' efforts as heroic, transcending the professional boundary through caring 'beyond the paycheck.' The ensuing sense of gratitude on the clients' part was reflected in statements such as "*[case manager] refused to let me live in the streets*" and "*she didn't leave me on the streets, you know?*"

Receiving tangible benefits from staff also motivated clients to participate in other aspects of the program, in several ways. Most simply, discovering that providers were able to deliver on promises of help encouraged clients to see the staff as a helpful resource in the future, thus motivating clients to remain engaged in the program to maintain the relationship. Secondly, clients felt that they were obligated to continue to take part in certain aspects of the program because of the help staff had given them; that is, they were influenced by a norm of reciprocity instantiated by the receipt of help and support. A staff member from the FACT team acknowledged this source of influence in the following statement:

Our ability to access funds to help people buy some clothing and hygiene items and get ID's and all that...I think that's one reason, certainly, why people are more likely to stay with us...especially during that initial period, and I think then when they get that concrete help, then maybe they're more willing to utilize whatever else we have to offer.

3.3.2. Engagement Manner—Engagement activities were supplemented by the providers' engagement manner, which refers to strategic methods of communication and self-presentation on the part of the providers. Instilling and sustaining in consumers a sense of motivation was a focal point for both programs, as staff believed this necessary to avoid client disengagement from the program and potential drug relapse or other illegal activities. Positive, encouraging dialogue was particularly essential for the CTI program, as their ability to connect consumers with other concrete resources, such as housing, was limited. As previously mentioned, however, both programs experienced a potential lag time between applying for benefits and the receipt of services. In the absence of forward progress that was tangible, such as finding employment or housing, program staff fostered positivity through talk, as suggested by this comment from a CTI provider:

When you listen to them and you don't judge them or you give them a sense of hope, it makes them get attracted to you, and when you show them that you care...

.... Even sometimes when they fall, they will let you know.... When you see them and you still encourage them, and say, “Look, we all do make mistakes. There is no perfect human being. Despite your body or whatever you can still make it. It breaks them and gives them the drive and the desire to make it.”

As suggested by this quotation, offering encouragement and positive words was seen by the staff as important in strengthening the bond between consumers and program staff and maintaining consumers’ hope when they encountered multiple roadblocks to achieving their goals. The quotation also illustrates that while engagement manner is strategic, it is nonetheless motivated and accompanied by genuine care and concern – a distinction framed in the literature on emotional labor as deep (as opposed to surface) acting in order to effect an empathic stance (Larson & Yao, 2005). Data drawn from the consumer perspective suggests that consumers appreciated providers’ methods of making suggestions for improvement that avoided blaming and judging. As one CTI consumer stated, his case manager’s efforts to reframe his situation were a lifeline during a period of deep discouragement:

If I got a problem I can call her and talk to her. She’ll come. ‘What’s the problem?’ and talk to me and let me know there’s other ways of going about doing things. Everybody still got stinkin’ thinkin’...It’s not like I’m this perfect guy. I’ve been trying though. I just feel like every door is getting shut in my face. Boom. Boom. Boom.

The consistency of these supportive narratives engendered within consumers a sense of being understood and truly cared for. By relating to consumers on this level, staff members achieved an authentic or “real” relationship that was often novel and incredibly valuable for consumers. As previously mentioned, consumers would reflect on their relationships with consumers as more personal, or intimate than is typical of client-provider interactions. The idea of strengthening a bond through caring, genuine dialogue was reflected in the FACT program as well:

I think you have to come to meet them eye to eye. ...Obviously there’s knowing that you’re the professional, and we’re trying to help, but also know that... I may understand what you’re going through at times, or really get down to where they’re at and see them for what’s really going on in their lives, and not make statements or decisions because I’m a professional, but because I know maybe what would really help them, or just seeing them at a same level

Authenticity was accomplished not only through the content of what providers said to clients, but also through the manner with which staff interacted with them. Adopting an engaging manner helped staff achieve congruence between their verbal and non-verbal exchanges with consumers; that is, the narratives of hope, encouragement, and solidarity also had to be supported by their actions and self presentation. One way of achieving this was by “leveling” with consumers, or removing elements of formality that could interfere with the authenticity of their interactions. Staff “leveled” with consumers in both literal and figurative ways; one consumer recalled his case manager entering his unfurnished apartment and sitting on the floor. This display of comfort with the consumer and commitment to spending time with him reinforced the “realness” of their relationship. A similar effect was

accomplished by remaining responsive to consumers' schedules; in order to maintain contact with consumers, staff would meet with them in a variety of locations. When a consumer found a job, one CTI staff recalled meeting with him in her car outside of his work. Staff members also provided clients with their phone numbers and made themselves available outside work hours. Both FACT and CTI staff regularly met with consumers in their own homes or other community locations that lacked the formal, clinical feel of program offices.

A second feature of the staff members' self presentation was to endeavor to appear non-judgmental in their interactions with consumers in order to avoid activating memories of previous negative service encounters. One of the FACT providers described the importance of listening without interjecting her own questions in early contacts with clients; as she put it, allowing consumers to speak freely communicated *"I'm not here to judge you, like maybe other people have in your life. That's not my goal."* All of these practices culminated in an informal, warm rapport that inverted clients' perceptions of authoritarian professional relationships.

3.3.3. Third Party Engagement—Staff in both programs reported that they would encourage third party collaterals in their clients' lives to encourage their participation in treatment. In the CTI program, staff members were more likely to report that they encouraged treatment participation between family members, whereas in the FACT program they were more likely to encourage participation via their parole officers.

3.3.3.1. Role of Family: Both the frequency and nature of family involvement differed between the CTI and FACT programs. These distinctions were driven both by the availability of resources and by fundamentally different program philosophies. The CTI program struggled with limited community resources and restrictive welfare eligibility policies that prevented consumers with drug distribution charges from accessing most forms of public benefits. For those with distribution charges, CTI staff had no potential housing options except time-limited emergency assistance; even access to a local homeless shelter required welfare eligibility. It was therefore essential that those clients who had family or other social networks in the Camden area seek shelter from their families, at least until they had a stable source of income (job or disability benefits). Involving family members in the CTI intervention therefore became an important strategy meeting very practical needs. A second reason the CTI staff depended upon family connections was as a way of locating and tracking the client over time. As discussed in an earlier section, the CTI team's practice of waiting for contact from the client following release risked loss of contact; thus, the team was deliberate about reaching out to family in advance of release to orient them to the program and how it could be of potential assistance to the client. Once the client was released, these family members served as a mode of contact for the individual as well as a source of encouragement to take up on the team's offerings of help. As one CTI case manager related:

Another individual that came out of the Philadelphia prison system. His brother was a pastor. [Consumer] was stayin' at a group home called My Brother's Keeper" and gettin' his brother involved with the pastor, gettin' him first [to] look at the religious side. I introduced myself to him and said, 'Look, we're gonna work

together to get your brother [consumer] where he needs to be.’ So we engaged his brother workin’ with us. Well because his brother was the influence in it, I think he engaged more, was more active in terms of workin’ with us. I think the family had played an important role. I use that as a help.

Because many consumers had tenuous relationships with family members, brokering a working relationship with family members was a critical skill for CTI staff, as it served to ease some of this tension and increase family willingness to take consumers in. The idea that consumers would be released from prison with the intensive support of staff members eased some of the anxiety felt by family members as they prepared for consumers to re-enter their lives. As one provider described:

“...Some of them that know, um, where their family members are and the family members are involved, we just try to – well, we make the initial call and we tell them what type of things we are going to be doing with them. It encourages them. Even for those that have said, “We don’t want to have anything to do with them,” it gives them hope and they want to give him another chance to see whether he can make it with this support that he now has, so we tell them that, “Well, he is coming back to work with the support team”

In contrast, the FACT team had the capacity to provide housing to consumers, and their program funds allowed team members to purchase and pay for consumers’ cell phones, affording team members a reliable line of communication with consumers. Although some of the FACT consumers had contact with their families upon release, FACT staff evinced less of a tendency to view this contact in purely supportive terms. That is, even if the staff viewed family relationships as valuable and important, they nonetheless perceived family members’ actions as working at cross purposes with their own interventions. FACT staff not only loaned clients money during the gap between application and receipt of benefits, but also managed the money for all but those consumers who went out of their way to secure another arrangement, which was typically to name a family member as a payee. When family members became involved in decisions about how to spend money, this produced friction with the FACT team. One consumer, for example, who lived with his mother on and off during his time in the program, gave his food stamp benefit card to his mother, and she sold the benefit to a convenience store in exchange for cash. In those kinds of situations, staff perceived that family was a poor influence on the client and a hindrance rather than a bolster to service engagement, as the following quotation illustrates:

There’s definitely – well, I would say overall our interactions with family have been neutral or negative. I can’t think of any situation that has been consistently positive. [Client Name] is staying with his mom. The mom doesn’t ... even let us come into the place anymore it seems like. Now granted, one of the other staff members told [off] the local place where she was selling [the client’s] food stamps... and so there have been some things that we have done that upset her, and she’s just not on board either at all with the idea that maybe he really needs that medication, or maybe there are some – it’s almost that she can’t see that there’s anything wrong with her son other than he needs to quit drinking, and so I think the

times when it's been negative, it's been because we've come from fundamental differences in the way we view that person, and what would help them.

The paternalism implied in the foregoing quotation was driven by the team's control over monetary resources; because they often paid consumers' bills and distributed the remainder as spending money, the FACT team was more directly affected by how and where consumers spent money, and whether they were in good standing with their landlords. In essence, FACT members often took on the role that family members would play in the CTI program. Determining who was truly responsible for the care of consumers therefore became a potential source of conflict between family and FACT staff. Such conflicts were further exacerbated when the FACT team perceived that the family was acting in ways contradictory to the client's best interest, such as draining the consumer's resources.

3.3.3.2. Parole Officers: One of the controversial issues in adapting mental health EBP's to the context of criminal justice is in determining whether and how to leverage criminal justice authority for therapeutic purposes (Cuddeback et al., 2009). Lamberti, Deem, Weisman, and LaDuke (2011) conducted a survey of FACT teams nationwide which showed that most programs feature at least some degree of collaboration between mental health professionals and criminal justice authorities, which can be formal (as would be the case when a parole or probation officer is a member of the clinical team) or informal (as would be the case when mental health and criminal justice officials share information and collaborate on treatment decisions). In either variation, the collaboration makes possible the use of legal leverage to enforce treatment engagement.

In the CTI team, most offenders were released after having served the maximum sentence, so very few were on parole while being served by the team. The CTI team supervisor also had responsibilities in another program in which she served as a liaison to the county jail, and this enabled her at times to locate CTI consumers lost to contact who had surfaced in jail. In the FACT program, being released on parole was much more common, and thus the providers on the team had more contact with parole officers. The team did not develop a formalized relationship with parole, and administrators who oversaw all of the criminal justice programs in the umbrella agency reported that the agency philosophy eschewed "therapeutic arrest" and other practices of treatment leverage. The team did report, however, that they sought to develop a relationship with parole officers that would enable them to request assistance in encouraging clients to remain engaged in treatment, not unlike the CTI team's practice of engaging families in the work of encouraging their family members. One team member commented, for example, that she would have preferred that parole take a more active role in pressuring a client, who generally avoided contact with the team, to participate:

I think that, you know, parole thought that she was doing very well, and for a while, you know, we thought she was doing very well. But she pretty quickly, you know, became I think pretty heavily involved in drugs for a period of time, and was really – was really not doing very well. And I had known her parole agent, and you know, again, I – you know, I was pretty confident that if I were to call her, you know, and say, "You know, hey – " You know, that she wouldn't come down real

hardcore on her, but she would – she would kind of increase her involvement. And she did to some extent, although actually, in that particular case, I sort of wish that she had – that she actually had maybe pressured a little bit more, because [Client Name] is not doing well, and parole isn't willing to really – you know, I don't know. I wish they were maybe seeing her more or something. She's – I guess she's in basic compliance with what they're asking her to do.

3.4. Engagement Differences Between Programs

Across both programs studied here, engagement was a central focus of early service provision with clients with mental illness in the community reentry process from state prisons. Providers in both programs engaged in activities and methods of interacting with clients and collaterals that sought to develop a relationship bond that would increase the client's investment in pursuing treatment goals and make it most feasible to provide individually tailored services. While traditional psychotherapy stresses the importance of interactional processes in the development of the therapeutic relationship, data from both studies presented here show that in reentry services, assisting clients in obtaining needed resources is equally as important as therapeutic techniques such as empathic responding in the engagement process. While the staff in both programs used similar strategies to engage clients, this study also found that the engagement process was not identical across programs. Our analysis suggests that while fundamental philosophical differences between the service models drove part of the difference in engagement processes, so also did context differences – particularly disparities in resources between the teams.

One source of dissimilitude was the differences in philosophy between the programs, particularly in terms of treatment duration and method of service delivery. CTI adheres to a strict 9 month time limit in services, in line with its transitional philosophy, and seeks to link the client to more permanent services; whereas FACT provides many of the services itself, for as long as the client needs services. In line with these distinctions, the CTI program sought to develop a strong working relationship while simultaneously guarding against the client becoming dependent upon that relationship. Instead, the team encouraged the client to make use of formal and informal supports wherever possible. One CTI staff member described that avoiding dependency was difficult because it required holding back support desired by the client. As he related in relation to one client,

Yeah; they wanted me to do everything for 'em. From pickin' 'em up and takin' them where they need to go, knowin' that they had their own transportation, but they just really depended on me, which I didn't mind, but I had to remind myself that I wasn't gonna be in this guy's life after nine months. So I had to sit down with him and say, 'Look, this is what you gonna have to do from now on. I can't do this for you no more. You're capable of doin' it. So this is what I need you to do. However, I'll still be involved, but because I know you can do this, you gonna have to do it on your own.'

In the FACT program, which follows a model that prescribes direct service provision rather than service linkages, staff were less cautious to avoid generating dependency of the clients on the team for support. In the early weeks of the program, accompanying clients to buy

needed supplies and resources served twin goals of helping the client adjust successfully to the community and to develop a bond in which the client perceived the relationship as gainful. The ongoing need for staff to act as mediators of resource transactions was heightened by the role as money managers, since they often controlled access to the client's money on a transaction-to-transaction basis. The resulting dependency of the clients on the staff to get the things they needed presented complications for the team over time, however, as they sought to encourage clients to take on tasks they were capable of doing independently, such as taking public transportation to stores and appointments. Once staff began to see clients as capable of more than they were doing, and as their caseloads grew, client requests for help took on a burdensome cast. One case manager, who in his first interview expressed pride in his ability to help clients get things they needed, had shifted to a stance of concern about promoting dependency by the second interview some months later:

I think what maybe one of the negative sides... is that maybe they get too dependent on that kind of work being put into them, and them not doing as many things on their own because of that, and I think that as a team we need to learn how to break that, and move past that. It's just really hard when they can seem really needy, and not being able to handle things at times on their own when, if they were on their own, they [would] have to.

Because CTI staff members were acutely aware of the time restriction of their program, their linkage-focused interventions were often focused on helping consumers locate a more permanent support network (typically family) and, lacking tangible resources to give clients, they worked instead establish a sense of hope that would support sustained motivation to work towards goals. The program philosophy was one of doing "with," rather than "for", consumers (see Floersch, 2003 for a full discussion of this distinction). This was evident in the strategies team members employed to connect them with support systems:

But there are some that don't have any form of support. We don't link them up with people. We just encourage them to develop their own – to make friends by themselves, because sometimes when you introduce them or you try to link them up, then it becomes a problem. If something happens, 'you put me into this,' so we encourage them to socialize and develop relationships for themselves.

Engagement processes were also affected by the resources available to program staff. FACT staff, having access to the revolving loan fund allowed them to engage clients by giving them "gifts" of shelter and supplies, even if these gifts were technically an advance on money the team anticipated that the client would eventually receive as back payment on a disability claim. Because receiving this assistance was so welcome and unexpected, accepting the help bound clients more tightly in a matrix of mutual obligation and also created a dynamic in which staff were more directly involved in their financial affairs. As money managers, staff employed discretion to dispense resources, requiring them to weigh client desires against clinical and moral judgments of need. The CTI staff, having at their disposal only cars, time, and knowledge about available resources, avoided deeper involvements in clients' private affairs. Instead, they encouraged clients to rely more upon their families for support and expended greater effort developing alliances with family

members to buttress that involvement. In contrast, the FACT team's access to money to provide housing meant that they did not require family participation. Furthermore, the necessity of transitioning clients over to natural support systems was absent in the FACT program because team members could work with consumers for as long as required. As a result, FACT staff themselves often became an important pillar of social support. Because they assumed a key support role, they often felt themselves to be in a contentious relationship with consumers' family members. At the same time, their more intimate staff-client relationships that constituted potent sources of social influence nonetheless presented challenges in preventing unnecessary dependency on the program.

4. Discussion

One of the biggest barriers to public health intervention in the context of reentry is that, upon release, former prisoners view health and mental health needs as secondary to economic considerations such as obtaining housing and employment (Davis et al., 2011). Consequently, public health approaches emphasize the importance of prerelease planning and transitional services to ensure that such needs are addressed in combination with information about and access to health care. In this study, we found that both reentry models employed a similarly holistic approach to engaging individuals with psychiatric disorders upon release from prison. That is, staff in both programs engaged former prisoners in seeking mental health care through the acts of advocating and accompanying the former prisoners as they sought housing, welfare and insurance benefits, and employment. This engagement process relies upon provider success in meeting concrete needs in order to engender trust, which is particularly important because former prisoners, like many in poverty, acquire significant levels of distrust over repeated experiences with personnel in corrections and social service bureaucracies (Levine, 2013). Providers in this study also worked strategically to offer concrete assistance in the context of a non-hierarchical relationship that further worked to mitigate former prisoners' past experiences of status disadvantage in interactions with professionals and other authorities.

This provision of instrumental and emotional support, provided in an empathic and nonjudgmental manner, is considered the hallmark of successful helping relationships, as has been well detailed in the social work and psychotherapy literatures (Marsh et al., 2012). This study underscores that while the essence of engagement is an interpersonal endeavor between provider and consumer, it nonetheless cannot be easily decoupled from the structural context of its provision. In this sense, the differences between the two programs exemplify Hasenfeld's (2010) explanatory model linking the institutional and political economy of organizations to the worker-client relations enacted within them. Mental health organizations such as the ones studied here respond to institutional pressures to conceptualize former prisoners who meet criteria for mental disorders as mental health clients who happen to have criminal records, through a process of engaging of those clients into mental health treatment. At the same time, institutionalized moral assumptions about criminal offenders are reproduced in welfare policies that constrain the work of engagement because it is so reliant on meeting basic needs before addressing psychiatric problems.

This perspective also highlights the limitations of engagement as an interpersonal process when it is enacted in an environment of resource scarcity. Programs such as CTI, which depend on linkage to services and supports, have little to offer when barriers in the policy environment (welfare and insurance disenfranchisement) disenfranchise consumers from accessing the social safety net and the mental health service system. In such instances, programs such as FACT, which are based on the ACT model, may prove more effective in closing the mental health service gap between prison and community because they imbed psychiatric services within the program. On the other hand, ACT services are increasingly considered unsustainable to provide over long periods of time because of their intensity and indefinite service length (Hackman & Stowell, 2009). These services are also considered vulnerable to creating dependency and furthering stigma and isolation from natural support networks, as was shown in this study.

4.1. Strengths and Limitations

Within the broad framework of qualitative research design, each study featured a triangulated design that included staff perspectives, client perspectives, and researcher observations obtained by prolonged entry into the field. Triangulation in qualitative research helps to provide depth and scope, bolstering credibility (Charmaz, 2006). It is nonetheless important to acknowledge that the design of the analysis presented here, which compared two programs in different locales and service contexts, has key limitations. While it is not our intention to cast either program as a pure example of either model, we do interpret differences between programs as due, in part, to model differences; we have sought to link these inferences with both qualitative research evidence and insights from literature about each model. However, further research is needed to determine whether the distinct features associated with each model (FACT and CTI) are indicative of these models more broadly, and not simply idiosyncratic to the programs we studied. Qualitative inquiry is well suited for the elucidation of processes rather than for broad generalization of substantive findings. For this reason, it is important to view the current study as providing insight into general practices of engagement in the context of reentry rather than as a definitive statement about model differences.

4.2. Implications

During the past decade, interventions to reduce the “criminalization” of people with mental illness – many of which are based on adapted evidence based interventions for mental illness – have proliferated nationwide. Recent reviews of the evidence in support of these interventions suggest outcomes which are modest at best (Skeem, Manchak, & Peterson, 2011; Wolff et al., 2012). In both reviews, the authors point the way forward to a new generation of interventions and policies which differentiate between subtypes of offenders with mental illness and which target criminogenic behavior rather than assuming that leveraging treatment adherence will lead to fewer people with mental illness in the criminal justice system. A more promising direction, they argue, is toward interventions that recognize that offending stems more often from poverty and learned criminogenic behavior than from untreated psychiatric symptoms. The findings of this study suggest that provider efforts to bolster successful community entry relied heavily on efforts to help clients obtain resources through advocacy and side-by-side assistance, and that these efforts were also

deemed the most useful for engaging justice-involved clients in the helping process. Whatever form the “second generation” (Wolff et al., 2012) of interventions takes, it is critical that these programs be “relationally savvy,” with issues of engagement considered carefully in their design. Our analysis suggests that because of the socioeconomically deprived state of newly released prisoners, provision of resources and emotional support will continue to be an important source of “relational leverage” for engaging clients in reentry programs. In practice and research, engagement is considered an interpersonal endeavor between provider and consumer; however, this study shows that the structure of a program such as duration of service (CTI, transitional; FACT, long-term), embedded resources (access to money for housing and basic needs), and orientation towards family involvement along with the community context have an effect on engagement processes. These factors should also be considered when designing second-generation interventions for this population.

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Figure 1.
Model of the engagement process