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ORIGINAL ARTICLE

Mental Health and Substance Abuse Service Engagement by Men and Women During Community Reentry Following Incarceration

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Abstract Individuals reentering the community following incarceration are at high risk for experiencing mental health and substance use problems. This longitudinal study explores patterns and barriers for engaging treatment services during early reentry. Seventy-five men and 62 women in jail, prison, or community based correctional facilities (CBCFs) participated in pre- and post-release interviews. Findings indicate that services were engaged at a lower-than-needed rate and barriers were greater for individuals leaving jails compared to prison or CBCF. Exploratory factor analysis of the barriers instrument is presented. Implications for extending service access to this population are discussed, as are future directions for research.

Keywords Prisoner community reentry · Mental health and substance use services · Barriers to service engagement

Introduction

At the end of 2012, almost 7 million adults were under the supervision of the correctional system in jails and prisons, or on probation or parole. This figure translates to 1 in every 35 adults (2.9 % of the adult population) who were either incarcerated or under community supervision (Glaze and Herberman 2013). Annually, over 637,000 men and women are released from state and federal prisons and reenter their communities (Carson and Golinelli 2013). Most of the 744,524 adults incarcerated in local U.S. jails at midyear 2012 will be released for community reentry within 2 years of admission (Minton 2013). These individuals are at high risk for physical and behavioral health morbidity and mortality compared to the general public (Mears and Cochran 2012; vanOlphen et al. 2006).

In one state, the relative risk of death from any cause during the first 2 weeks post-release from prison was 12.7 times the risk for other residents; the leading cause of death was drug overdose, followed by cardiovascular disease, homicide, and suicide (Binswanger et al. 2007). Federal surveys of inmates in state and federal correctional facilities in 2004 and in local jails in 2002 identified rates of depression, mania, and psychotic disorders at rates considerably higher than among the general adult population (James and Glaze 2006). Major depression was evident for 23.5 % of state prisoners and 29.7 % of jail inmates, compared to 7.9 % in the general population; mania disorders were present among 43.2 % of state prisoners and 54.5 % of jail inmates, compared to 1.8 % of the general population; and, psychotic disorders were experienced by 15.4 % of state prisoners and 23.9 % of jail inmates, compared to 3.1 % of the general population. Over half of state prisoners (53 %) met diagnostic criteria for a substance use disorder in 2004 (Mumola and Karberg 2006) and among jail inmates in 2002, 68 % met criteria for alcohol or other substance dependence or abuse (Karberg and James 2005). Compared to the general population, substance use disorders are seven times more common among jail inmates (Teitelbaum and Hoffman 2013). Furthermore,

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among prison and jail inmates who experience mental health problems, about three-quarters also met criteria for a substance use disorder (James and Glaze 2006).

With large numbers of former inmates having mental health and substance use problems, clearly there is a need for behavioral health and addiction services in their reentry communities. Inmates in three studies were asked to identify their most significant needs at reentry (Hatcher 2010; Notley et al. 2012; Wilson and Draine 2006; Woods et al. 2013). Participants listed substance abuse treatment, housing, healthcare, and social services as important, and also suggested wrap-around services. Criminal justice scholars have noted that among individuals with substance use disorders, the transition back into the community is a period particularly vulnerable to relapse if strong treatment opportunities are not provided, even if drug use ceased during incarceration (Belenko 2006; Harrison 2001).

Continuity of behavioral health and addiction services during the transition between incarceration and community reentry is a crucial factor in determining reentry success (Baillargeon et al. 2010; Belenko 2006; Bond and Gittell 2010; Osher et al. 2003; Rich et al. 2001; Seredycz 2010; Teitelbaum and Hoffman 2013; Wolff et al. 2005). The initial post-release period, at least the first 90 days, is considered to be a critical period during the reentry transition: a time when immediate access and linkage to needed services is most intense and important for long-term outcomes (Fontaine et al. 2012; Freudenberg 2001; Goldstein et al. 2009; Hammett et al. 2001; Mellow et al. 2008; Redko et al. 2006; Rich et al. 2001; Richie et al. 2001; Seredycz 2010; The Urban Institute 2002; vanOlphen et al. 2006). Problems with substance use represent significant barriers to community reintegration and an individual's ability to benefit from other reentry services (vanOlphen et al. 2006). For example, the most significant obstacle to individuals' realizing continuity of care for HIV infection is an ongoing addiction (Rich et al. 2001), and HIV is a common health concern present among many individuals with a substance use disorder (Belenko 2006).

Numerous studies note that service needs to promote positive reentry outcomes are not well met (Davis et al. 2008; Mann et al. 2011; Richie 2001). The literature also suggests that the experience of reentry needs may be different when comparing men and women; especially considering evidence that incarcerated women have higher rates and/or greater severity of many mental health and substance use disorders than incarcerated men (Begun et al. 2009, 2011; Blitz et al. 2005; Frisman et al. 2010). The referral pathways to treatment services (at least for addiction problems) may differ for men and women (Grant 1997). Gender-specific assessment and treatment programs may be needed to address women's complex mental health concerns, particularly trauma-informed services (Blitz et al. 2005; Richie 2001; Richie et al. 2001). Women's lives during reentry also may be complicated by virtue of their being mothers (approximately three-quarters of them are), as they need services that will help them regain custody of their children and programs that work around their children's care needs (Belenko 2006; Gouvis Roman and Travis 2004; Oser et al. 2009; Richie 2001; Richie et al. 2001).

Instead of continuity of care, studies indicate that during reentry individuals often experience a pattern of fragmented mental health services and significant service breaks (Baillargeon et al. 2010; Lurigio 2001). Even when receiving post-release mental health services, in a study of 337 men and women, "few received clinically meaningful levels of service during the first year after release" (Lovell et al. 2002, p. 1290). This is despite evidence that receiving mental health treatment during reentry is associated with lower re-incarceration rates (Kerr and Lockshin 2010; Mann et al. 2011).

Barriers to receiving services include eligibility problems, loss of insurance during incarceration, and inability to meet service costs (Lurigio 2001; Mojtabi et al. 2011; Osher et al 2003). Additional barriers experienced by reentering prisoners include: inadequate discharge/transition planning, insufficient numbers of public mental health programs in the community, difficulty with getting an appointment soon after release, community-based programs being unable to adequately meet the needs of an ex-prisoner population, the double stigma of mental illness and ex-prisoner status, and not believing that treatment will be effective or is needed (Baillargeon et al 2010; Mojtabi et al. 2011).

In terms of substance use disorders, an additional barrier is that even if individuals qualify for Medicaid assistance, services are often limited for treatment of substance use disorders (Cuellar and Cheema 2012). Other policy restrictions also may interfere with meeting inmates' reentry service needs. For example, policies may preclude individuals convicted of a drug-related felony from receiving Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP/food stamps), federally subsidized housing, and higher education benefits (GAO 2005; McCarty et al. 2013). Reentering prisoners are often mandated to demonstrate abstinence, take drug tests, and attend twelve-step or self-help group sessions as a condition of probation; these are too often accepted as a form of treatment in lieu of addiction-specific, intensive treatment services (Harrison 2001; Sung et al. 2011). Among reentering individuals, there is a demand for treatment immediately upon release, but the supply is often insufficient, resulting in long delays for treatment services. When these services do become available, they may be too brief in duration and inadequately meet the individual's treatment needs (Harrison 2001; Redko et al. 2006). For women, "the

quality and gender-appropriateness of drug treatment is as important as treatment access" (Freudenberg et al. 2008, p. s199).

Reentry processes remain a "black box" phenomenon with considerable local and state-level variability in how this process is managed (Cuellar and Cheema 2012; Mann et al. 2011; Pogorzelski et al. 2005; Rich et al. 2001; Seredycz 2010) Mears and Cochran (2012) discuss the importance of developing a better understanding of the gap between needs and services, and others suggest there is a lack of empirical evidence concerning the use of services by offenders returning to the community (Mellow et al. 2008).

The Present Study

This short-term, longitudinal study was designed to: (1) identify discrepancies between service needs and service engagement related to substance use and mental health problems; (2) explore the nature of barriers to service engagement; (3) identify significant differences between men's and women's reentry service needs, engagement, and barriers; and, (4) identify differences for individuals returning to the community from jails, prison, or community based correctional facilities (CBCFs). We recruited participants shortly before their planned release dates and collected Time 1 data through individual, in-person, structured interviews. We then re-contacted participants by telephone (Time 2) to schedule in-person, follow-up interviews (Time 3) in the community. All participants engaged in an informed consent process, and the procedures involved in the study were reviewed by the University's Office of Responsible Research Practices, as well as by the state's Department of Rehabilitation and Corrections. The initial interviews lasted approximately 40 min, and the post-release follow-up interviews lasted approximately 20–30 min each. The same measures were used at both time points except that the Time 3 follow-up interviews excluded demographic items that do not change over time and referenced the time since release instead of the year prior to incarceration. Per institutional policy, participants were not allowed to receive any form of incentive while incarcerated; they received a $30 gift card when the final interviews were conducted in the community.

Methods

Participants

Individuals scheduled for release from county jails, state prisons, and CBCFs within 2–4 weeks were recruited. The inclusion criteria were: (1) expecting release within the next month, (2) expecting to reside in one of the target counties, and (3) expecting to reside in a minimally regulated setting. It is not known how many individuals were eligible for participation from each facility. A total of 309 inmates, aged 18–63 years, completed a Time 1 interview in one of four jails, six prisons, or four CBCFs (see Table 1 for information concerning characteristics and distribution of participants). Of the initial participants, 44 % (N = 137) also completed the final (Time 3), post-release interview. More men than women were recruited into the initial sample (58 vs. 42 %); this difference narrowed somewhat among those remaining in the study during the Time 3 post-release interviews (55 % men vs. 45 % women). Participants retained during reentry versus those lost to follow-up did not differ significantly on variables of interest or demographic variables (see Table 1). However, the study attrition rates were not even across type of facility: 67 % of individuals in jail settings at time 1 were missing at the post-release follow-up, compared to 50 and 56 % of individuals from prison or CBCF settings.

Measures

Demographics and Quality of Life Demographic and quality of life portions of the interview were excerpted from the state's Mental Health Consumer Outcomes System: Adult Consumer Form, which is a structured instrument for assessing how services may or may not be helping the respondent. The variables included date of birth, date of interview, gender, race/ethnicity, education, employment, relationships, housing, health, substance abuse, and mental health status, as well as a brief incarceration history.

Integrated with several demographic items were questions concerning the participant's plans (e.g., when you leave here, do you plan to complete additional education) and life circumstances prior to incarceration. In addition, the interview schedule included a quality of life scale covering how respondents felt about their education, employment, housing/living situation, health, relationships, children's care, substance use/abuse, and mental health status (0 = terrible, 1 = mostly dissatisfied, 2 = equally satisfied/dissatisfied, 3 = mostly satisfied, and 4 = very pleased).

Substance Abuse The interview included four questions concerning the participant's relationship to alcohol or other drug involvement. Previous attempts to change a problem with alcohol or drugs were probed via a checklist of various interventions ranging from inpatient treatment to trying to change the problem through willpower or religion. The Alcohol Use Disorders Identification Test Including Drugs (AUDIT-ID, or the AUDIT-12; Campbell et al.

Table 1 Participant distribution across variables: Contrasts for time 3 versus drop outs from time 1

	Time 1	Time 3 sample only	Contrasts
Total	309	137 (44 %)	–
Gender			
Men	180 (58 %)	75 (55 %)	*NS*
Women	129 (42 %)	62 (45 %)	$\chi^2(1) = 1.54$, $p = .214$
Type of facility			
Jail	67 (22 %)	22 (16 %)	*NS*
Prison	144 (47 %)	72 (53 %)	$\chi^2(2) = 5.45$, $p = .065$
CBCF	95 (31 %)	42 (31 %)	–
Age			
Mean	33.80	34.96	*NS*
(Std dev)	(10.01)	(9.67)	$t(135) = 1.395$, $p = .165$
Median	32	33.5	
Ethnicity/race			
White	200 (69 %)	90 (66 %)	*NS*
Black, Non-Hispanic	79 (27 %)	31 (23 %)	$\chi^2(2) = 2.45$, $p = .293$
Other, combined	13 (4 %)	16 (11 %)	–
Relationship			
Married/living together	55 (18 %)	30 (23 %)	*NS*
Not in relationship	254 (82 %)	102 (77 %)	$\chi^2(1) = 2.75$, $p = .097$
AUDIT scores at time 1			
Number of abstainers	45 (15 %)	21 (15 %)	*NS*
Mean	15.6	15.56	–
Median	17	17	$F(1,262) = .00$, $p = .99$
Number negative (<8)	63 (24 %)	27 (23 %)	
Number positive (≥8)	201 (76 %)	89 (77 %)	$\chi^2(1) = 0.052$, $p = .82$
AUDIT scores at time 3			
Number of abstainers	–	56 (41 %)	–
Mean	–	4	–
Median	–	1	–
Number negative (<8)	–	66 (75 %)	–
Number positive (≥8)	–	15 (17 %)	–
Need for substance use services during reentry[a]	193 (62.5 %)	63 (44 %)	–
Need for mental health services during reentry[a]	174 (56.5 %)	69 (48 %)	–
Need only substance use services	56 (18 %)	19 (13 %)	–
Need only mental health services	38 (12 %)	25 (17.5 %)	–
Need both types of services	136 (44 %)	44 (31 %)	–
Neither type of service needed	78 (25 %)	55 (38 %)	–

[a] These are overlapping categories; individuals may belong in either, both, or neither

2001) referenced use patterns during the last year prior to incarceration (Time 1) or the time since release (Time 3).

The twelve-item AUDIT-ID is a modification of the routinely applied, ten-item AUDIT (Allen et al. 1997; Reinert and Allen 2002; Saunders et al. 1993). The AUDIT-ID includes a question about use of substances other than alcohol to "get high or change your mood" that is scored identically to the alcohol frequency item on the original AUDIT, and also includes a question about the frequency with which two or more substances (including alcohol) were used on the same occasion. In addition, the subsequent seven AUDIT-ID items ask about drinking and drug use together, rather than alcohol alone. The general screening cut-points recommended by (Babor et al. 2001) for scores computed as the sum of response scores were applied to the AUDIT-ID, such that a score of eight or

higher represents a "positive" screen result (in this case, applied to both men and women). Scores over 16 reflect a very high risk for a substance use disorder.

A general screening question about the perceived need for substance use treatment services was asked of each individual regardless of earlier responses and as an indicator of whether additional substance abuse service questions were appropriate. The screening question was asked in terms of anticipated need during reentry for the time 1 interviews and about experienced need during the reentry period follow-up interviews. This item asked each participant to rate how much they thought they might need treatment, counseling, self-help groups, or medication to help address problems with alcohol or other drugs (1 = not at all to 5 = extremely).

Mental Health Similarly to the substance abuse domain, mental health concerns were included in the quality of life ratings, and past attempts to change mental health problems were probed via a checklist of mental health treatment, counseling, and self-help approaches. As a general mental health needs screening question, regardless of earlier responses and indicative of whether to ask further mental health services items, each participant was asked to rate how much they thought they might need counseling, self-help groups, or medication to have better control over thoughts, moods and actions (1 = not at all to 5 = extremely). Again, the screening question was asked in terms of anticipated need during reentry for the time 1 interviews and about experienced need during the reentry period follow-up interviews.

Barriers to Services Rose et al. (2014) presented a review of literature concerning the types of barriers to substance abuse treatment typically encountered by women. They describe results from the Allen Barriers to Treatment Instrument (ABTI) in work with women reentering the community following release from jail. A modified version of the instrument they used was adopted in the present study with items being made gender-neutral for application with men and women and several items being eliminated, added, or reworded for clarity. Two versions were created: one for substance abuse treatment barriers and the other about barriers to mental health services. The original ABTI was developed specifically for women and referred specifically to addiction treatment services. The current modifications included clarifications in wording, removing content on gender-specific services, and substitution of mental health language for substance-related content in the mental health barriers version. These two inventories contain 30 items each, rated as being 1 = not a barrier at all, 2 = somewhat of a barrier, 3 = a significant barrier, or 4 = a major barrier. Each barrier measure commenced with the general "needs" screening questions described above; if no need for that type of service existed, the barrier scale was not administered. The service barrier questions were asked in terms of anticipated barriers during reentry for the time 1 interviews and about experienced barriers for the follow-up interviews.

Exploratory factor analysis (EFA), conducted with the entire sample of Time 1 ratings, reduced the 30-item barrier scales to seven factors. This factor structure was then imposed on the Time 3 data. A total of 230 from the original 309 participants had needs related to either substance or mental health problems. Of these, 135 had both types of needs. To avoid over-representation of these 135 participants in the factor analysis, we randomly selected either their substance abuse or their mental health treatment barrier scores to include in the analysis. The preliminary Kaiser–Meyer–Olkin (KMO) measure was 0.813—close to the suggested value of 1.0—an indication that analyzing the variables using EFA could be useful. Furthermore, Bartlett's Test of Sphericity, significant at the $p < .001$ level, suggests that the correlation matrix for the 30 variables has strong enough associations to warrant EFA.

The EFA used a principal axis factor extraction and oblique rotation. The analyses were forced into six possible solutions ranging between four and nine factors. The screeplot analysis was best suited to the seven factor solution and EFA with fewer factors proved unsatisfactory. This seven-factor solution explains 56 % of the total variance and all eigen values remained >1. Chronbach's alpha values for the seven factors were all in the .628–.849 range (see Table 2). It should be noted that three factors had only two items each, which can contribute to factor instability.

The Rose et al. (2014) team also found that a seven-factor structure best fit the instrument from which the current one was derived. Their seven factors included some similar, though not identical, constructs. For example, Characteristics of Treatment was similar to their Program Characteristics, Transportation reflected their Treatment Site Access, No Resources to Pay for Treatment matched their Financial Access, and Competing Responsibilities and Children reflected their Children and Work Obligations. Their factor called Personal Beliefs about Use & Recovery overlapped with the current study's factors called Shame about the Problem or Treatment and Not Ready to Make Changes.

Procedures

Selecting Facilities Maps of the counties served by each prison and CBCF were overlaid on a map of counties served by the jails. Where the three types of facilities intersected, institutional recruitment was initiated. The purpose of adopting this strategy was to increase the probability that participants from the three types of facilities would be released to the same communities, thereby

Table 2 Factor Items with EFA loadings and Chronbach's alpha reliability scores

Factor identity	ICC***	Item contents	Factor loading
1: Characteristics of treatment	.687	5: Treatment staff cannot understand all that I have been through	.759
		12: I will have to wait for an opening, as most treatment programs are full	.302
		21: The behavior of treatment program staff towards clients is not helpful	.390
		29: I will have to talk about things in my past that I would rather forget	.432
2: Not knowing about treatment programs	.849	7: I don't know what treatment programs are available	−.745
		9: I don't know the location of any treatment programs	−.705
3: Competing responsibilities/ children	.679	14: My responsibilities at home don'tleave any time for treatment	.639
		15: My responsibilities as a parent make it hard to get away to seek help	.786
		23: No one will watch my children while I get help	.472
		27: I am afraid if I seek help, this could be used by someone to take mychildren away	.387
4. Shame about problem or treatment	.628	2: I am ashamed to admit that I have this problem	−.466
		3: I am afraid if I try to get help, people in my church will find out I have a problem	−.817
		4: My religious beliefs are in conflict with seeking outside help for (alcohol or drug use/ my mental health problems)	−.577
5. No resources to pay for treatment	.749	19: I cannot pay for treatment	.623
		30: I don't have health insurance that will cover treatment	.567
6. Transportation difficulties	.712	20: There is no good public transportation to the treatment program	.508
		25: The treatment programs are a long way from my home	.450
7. Not ready to make changes	.674	10: I don't want to (quit using alcohol or drugs, I just want to cut down/change this about myself)	.561
			.355
		16: I *need* (alcohol or drugs/to keep doing things the way I am doing them) in order to deal with the stress of daily life	.750
			.305
		17: I am not ready to work on (my alcohol or drug/mental health) problem	
		22: I don't think I can be successful in solving my (alcohol or drug/mental health) problems	

*** Indicates all were significantly different from zero at $p < .001$

facilitating the interpretation of the reentry experiences data.

Participant Recruitment In jails and CBCFs, recruitment was undertaken by means of flyers posted in men's and women's housing units with interested individuals notifying jail staff. For prisons, a project team member identified individuals with approaching release dates, then arranged to meet with interested individuals to explain the project and solicit their participation. The recruitment materials indicated that the purpose of Project RISE was to gather information to help inform decision-makers about services that could improve community reentry experiences. Interview dates were scheduled for group administration of consent procedures followed by individual interviews with those providing informed consent.

Two-week post-release telephone calls were made to each participant to conduct a tracking interview and schedule the final, in-person interview. If the original contact information was not sufficient, we sent the personalized letters to the tracking informants and attempted to contact these individuals by telephone and/or letter with information as to how the participant could contact the team for scheduling the final interview. Final interviews were scheduled as early in the time-frame as possible. Missed appointments were followed up and rescheduled as many times as necessary until the interview took place, the person withdrew from the study (only a few cases), or the person timed-out of the study (more than 4 months post-release).

Follow-up interviews were held in privacy at the participant's preferred location in the community where he or she resided: an office where community corrections appointments were held, a behavioral health setting, or a public library. Follow-up interviews concluded with offering the participant feedback on the screening measures; all interviewers were trained to provide this information using a motivational interview (MI) feedback format. Participants were then presented with a resource guide of community services and the participation incentive.

Data Entry In order to minimize data entry errors, all data were recorded on forms designed in Microsoft Word® for scanning into Remark Office OMR® version 7.0 (Gravic® 2008) and conversion to SPSS v.21 statistical data files.

Results

Descriptive results address participants' anticipated and actual service needs during reentry as well as the nature and extent of barriers experienced around engaging needed substance abuse and mental health services. Comparative statistical analyses address the research questions.

Service Needs

Substance Abuse Services During the time 1 interviews, more than half (62.5 %) of participants anticipated that they might have at least some need for services to address a problem with substance abuse. At the post-release interviews, slightly less than half (44 %) reported actually experiencing this type of need. Table 1 presents information regarding the distribution of needs for either, both, or neither of the two types of service needs, substance abuse and/or mental health.

Just prior to participants' release, AUDIT-ID scores reflecting the year prior to incarceration indicated that 82.5 % of participants engaged in levels of alcohol and/or other substance use that placed them at risk for a substance use disorder. In fact, 64 % were at very high risk, having scores of 16 or more on this brief screen measure. Almost half of participants (49 %) reported engaging in binge or risky drinking (5 or more drinks in a day at least monthly) during the year prior to incarceration and 56 % reported using other substances from two times per week to daily.

During reentry, 8 % engaged in risky drinking patterns, and 1 % used other substances twice a week to daily. Among those re-screened at Time 3, only 16 % had positive screen scores and only 7 % were at very high risk for a substance use disorder. Following release, 44 % still felt the need for this type of help. Although 45 % of participants had engaged in some effort to change a problem with substance abuse since release, only 21 % received professional help, including medication, individual or group counseling, or formal treatment. Their other efforts included various combinations of 12-step or self-help groups (28 %) and a variety of self-change strategies (33 %). Most individuals employed two or more types of change strategies.

The difference in pre-incarceration AUDIT-ID scores (Time 1) for women versus men completing the longitudinal study (N = 137) was not significant at the $p < .05$ level (one-way ANOVA); post-release, Time 3 AUDIT-ID scores for men and women also did not differ significantly. The mean pre-incarceration AUDIT-ID scores for participants leaving jail was 16.38, for prison the mean was 18.58, and for CBCFs the mean was 26.98. These differences were significant in a one-way ANOVA, where $F(2,134) = 9.77$, $p < .001$. Post-hoc Tukey's analysis was significant for the contrasts involving CBCFs.

Mental Health Services At Time 1, 56.5 % % of participants anticipated at least a little bit of need for mental health services during reentry. Approximately 54 % had engaged some form of mental health care prior to or during their incarceration; however, 68.5 % had been prescribed medication for mood, behavior, or emotional issues at some point in the past. During community reentry, 48 % of participants stated that they needed mental health services, but only 15 % reported actually receiving any, which primarily consisted of individual counseling or medication for mood or psychiatric problems.

Service Barriers

Service barriers were explored through two types of variables: the number of barriers (out of a possible 30) for each of the two service domains and ratings regarding the extent to which each category of barrier was encountered.

Number of Barriers The average number of barriers to receiving treatment for substance use disorders experienced during reentry (Time 3) was 4.54 ($sd = 4.69$); the median number of barriers was 3. The average number of reported barriers to mental health services at Time 3 was 5.6 barriers ($sd = 4.62$) and the median was 4.5 barriers. The mean ratings for the average number of barriers did not differ significantly between men and women on any of the factors for either substance or mental health related treatment services (one-way ANOVA).While lower, the mean number of barriers for the 25 individuals who received substance abuse services ($M = 3.32$) was not significantly so compared with the 35 individuals who did not receive these services during the reentry period ($M = 5.34$). The same pattern was observed in analysis comparing the 18 individuals who received mental health services during reentry (M barriers = 4.44) with the 52 who did not ($M = 5.94$). These one-way ANOVA results may have been affected by the large standard deviation which exceeded the mean for the individuals who did receive the analyzed services ($sd = 3.7939$ for recipients of substance abuse services and $sd = 5.0319$ for those receiving mental health services).

Participant reports of the number of barriers encountered during reentry differed among types of facility (jail, prison, CBCF) of incarceration. The number of barriers to substance-related treatment was significantly higher for individuals released from jails ($M = 9.55$) compared to those leaving prison ($M = 2.94$) or CBCFs ($M = 3.65$) on one-way ANOVA, where $F(2,61) = 10.09$, and $p < .001$, and post hoc tests showing significance only for the jail scores. Likewise, barriers to mental health services differed by type of facility: for participants released from jail, the mean

number of barriers encountered was 8.81, and was lower for those released from prison ($M = 5.43$) and CBCF ($M = 4.05$; $F(2,68) = 4.17$, $p < .05$; post hoc analyses significant only for the jail scores).

Barrier Ratings The seven-factor structure was used to compute post-release, Time 3 barrier magnitude scores. The mean ratings for each of the seven scales on barriers to substance-related treatment were relatively equal; the only type of barrier that stood out as somewhat greater than the others was Factor 5, reflecting an inability to pay for treatment services. The results were remarkably similar on the scales for barriers to mental health services (see Table 3).

Group Comparisons None of the analyses showed significant differences between men and women on the magnitude of any barrier factors for either substance use or mental health treatment services. However, scores for the barriers reflected in Factor 1 (Characteristics of Treatment), Factor 2 (Not Knowing about Programs), and Factor 7(Not Ready to Change) differed significantly by type of facility from which a person was released. Factor 1 had the highest mean for individuals released from jail ($M = 1.93$) compared to those from prison ($M = 1.10$) or CBCFs ($M = 1.24$), where $F(2,61) = 8.70$, $p < .001$. Likewise, the highest mean for Factor 2 was for participants released from jail ($M = 1.82$), compared to prisons ($M = 1.03$) or CBCFs ($M = 1.\ 12$) where $F(2,60) = 8.89$, $p < .001$. Again, for Factor 7, those from jail had the highest mean ($M = 1.89$) compared to those from prison ($M = 1.12$) or CBCFs ($M = 1.05$), where $F(2,61) = 16.88$, $p < .001$. Tukey's post hoc analysis was significant only for jail contrasts.

With regard to barrier ratings for mental health services, the same three factors showed significant differences by type of facility, with the means for jails again being higher than for prisons or CBCFs. The Characteristics of Treatment (Factor 1) mean for those released from jail was 1.91, as compared to prison ($M = 1.34$) or CBCFs ($M = 1.25$), where $F(2,68) = 5.79$, $p < .01$. The mean on the factor Not Knowing About Programs (Factor 2) was 2.14 for those released from jail, $M = 1.28$ from prison, and $M = 1.18$ from CBCFs, where $F(2,67) = 7.48$, $p < .001$. The Not Ready to Change scale (Factor 7) had a mean of 1.50 for those released from jail, $M = 1.23$ from prison and $M = 1.08$ from CBCF, where $F(2,68) = 5.64$, $p < .01$. Tukey's post hoc analysis was significant only for jail contrasts.

Discussion

Similar to other studies of persons released from incarceration, pre-incarceration substance use was high among most of the participants in this study. Binge or risky drinking was common, as was use of other substances, from twice per week to daily. Almost two-thirds of participants anticipated needing at least a small amount of help to address problems with alcohol or other drugs following release. Mental health problems also were common with almost 70 % of participants having been prescribed medication for mood, behavior, or emotional issues and more than half having engaged in some form of mental health treatment prior to or during incarceration. Forty percent of participants anticipated needing some mental health services following release.

The results suggest that engaging substance use or mental health services during reentry is a highly variable phenomenon across individuals. During reentry, however, even more participants described a need for mental health services but only a small minority had actually received any mental health care since release. Many participants had made attempts to change a substance use problem since their release, with fewer using professional help than either 12-step or self-change strategies. Although substantially fewer participants met the screening threshold for substance use problems during reentry, and <10 % of participants were at very high risk for a substance use disorder, closer to half of the participants stated a need for help with substance use during reentry. Barriers to receiving substance use services and mental health care were numerous and greater for mental health care. Inability to pay for services was more of a barrier to receiving both substance

Table 3 Descriptive statistics for seven factors, time 3 data

	Substance treatment barrier ratings		Mental health service barrier ratings	
	Mean (N = 63)	*sd*	Mean (N = 70)	*sd*
Factor 1	1.33	.6107	1.41	.5776
Factor 2	1.21	.5906	1.38	.7677
Factor 3	1.12	.2763	1.14	.2844
Factor 4	1.07	.2103	1.10	.2378
Factor 5	1.65	1.0497	2.00	1.1765
Factor 6	1.34	.7061	1.43	.7861
Factor 7	1.21	.5176	1.23	.3539

use and mental health services than any other type of barrier. Both needs and barriers were greater and service engagement lower among participants released from county or regional jails than participants released from prison or CBCFs. Conversely, AUDIT-ID scores for the pre-incarceration period of participants from CBCFs were significantly greater than participants from jails or prison.

Thus, this study was able to document unmet needs for substance use and mental health services among a population of adults reentering society after release from incarceration and some of the differences by type of incarceration facility. The results indicate that the reentry needs of people who have been in jail are even greater than those of people who have been in treatment-specialized corrections facilities (CBCFs) or prison, and that more barriers to treatment are experienced by individuals released from jail. The results also indicate that CBCFs are serving women and men with the most serious risk of substance use disorders.

The study is limited in that the participants were a convenience sample chosen for their impending planned release from incarceration in a single Midwestern state. Because there was not a sampling frame, it is not possible to calculate a response rate. Furthermore, the rate of attrition from this longitudinal study between the time of incarceration and the follow-up reentry period was not only considerable, it was most likely not a random factor. Attrition among individuals leaving jails was higher than among the other two groups, for example. This, in turn, may have an impact on the pre-release versus reentry follow-up data analyses.

Given the extent of prior substance use and mental health issues, incarceration should be thought of as a potential stage for substance use and mental health treatment, with attention to planning for reentry transition. The American Association of Community Psychiatrists (2001) and other scholars support the concept of transition planning to indicate shared responsibility across systems and organizations, and to highlight that care is neither beginning nor ending, but changing (Bond and Gittell 2010; Freudenberg, 2001; Hipp et al. 2009; Pettus and Severson 2006). Envisioned as a multi-stage process, the earliest stage of transition planning ideally begins with good assessment when an individual enters the correctional facility, followed by the provision of needed services during incarceration and linkages to needed services during the reentry transition (Baillargeon et al. 2010; Belenko 2006; Davis et al. 2008; Freudenberg 2001; Osher et al. 2003). Although the state's (Ohio) 2002 Plan for Productive Offender Reentry and Recidivism Reduction calls for such services delivered through prison staff and partnerships with local agencies (ODRC 2002), and Reentry Coordinators are currently affiliated with each of the state's prison facilities, it is not clear how consistently these activities are implemented.

In contrast, a 2012 evaluation of the state's jails reports that most make available at least minimal physical and mental health services, but inmates report a great deal of dissatisfaction with these services (Martin et al. 2012). Similarly, if physical and mental health services in jails are lacking, it is unlikely that linkages are made to post-incarceration services. As partial solutions to difficulties in accessing substance use and mental health treatment services following incarceration, community mental health programs should offer "priority services" to ex-offenders during reentry, and a group of interviewed inmates also expressed a desire for programming that eliminated being waitlisted behind individuals without criminal records (Hatcher 2007; Thompson et al. 2003). Research concerning a jail in-reach program for women that includes brief screening and feedback delivered in a motivational interviewing format, including conversation regarding anticipated barriers, showed a positive effect on reducing substance use during the reentry period (Begun et al. 2009; Begun et al. 2010, 2011). This strategy is a partial response to the observation that individually tailored discharge plans may be difficult to implement in jail settings where the timeline available for this work is often shorter and less predictable than in prison and CBCF settings.

The implications of this study include that, regardless of plans that specify attention to reentry needs, more space availability in substance abuse and mental health services is needed, better linkages are needed between incarceration facilities and community service providers, and additional financial resources are needed to help pay for services. Under Ohio's recent (and contested) Medicaid expansion, many individuals reentering the community following incarceration are eligible for Medicaid covered services. The *Columbus Dispatch* (4/20/2014) reported that prison officials are assisting inmates with enrollment in Medicaid prior to their release, but it is unclear whether jail officials are also doing so. Perhaps other changes in the healthcare system related to implementation of the Affordable Care Act (ACA) will reduce the financial needs gap. Further research is needed to determine whether these changes will be sufficient or whether the gap remains.

In contrast to other studies and the researchers' hypothesis, women and men faced similar levels of barriers to and need for substance use and mental health treatment. Further research in this area may help explain why the expected differences were not observed.

Not surprisingly, levels of need and barriers experienced differed by facility type. Participants released from CBCFs had significantly more severe need for substance use treatment, as indicated by higher AUDIT-ID scores. The CBCFs are designed specifically to provide treatment

among offenders identified as having a need; thus, higher need among them is expected. It appears, however, that greater numbers of inmates could benefit from treatment if there were additional CBCF capacity or similar services were provided in prisons and jails. Participants released from jails faced significantly more and more serious barriers to both substance use and mental health treatment, an indication that local substance use and mental health treatment authorities could better intervene with prisoners in need of services both during and after incarceration.

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