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Benefits of a Community Reentry Intervention for Reentry Self-Efficacy in Homeless Shelter Residents With Past Incarceration

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Abstract

The U.S. has one of the highest levels of incarceration and recidivism in the world (American Civil Liberties Union, 2022; U.S. Department of Justice, n.d). Several factors contribute to recidivism, including the loss of monetary funds and loss of housing upon incarceration. Homelessness especially predicts recidivism. It has been found to increase the risk of recidivism by almost 50% (Jacobs & Gottlieb, 2020). Within the context of a long-term ongoing participatory community action research Project in homeless shelters (Reeb et al., 2024), this study examined the benefit of reentry support sessions within the homeless shelter environment, with an attempt to overcome barriers in utilizing community resources. In this study, 20 previously incarcerated, unhoused men participated in a reentry support session within St. Vincent De Paul's Gateway Shelter for Men (Dayton, Ohio). The reentry support session was developed in collaboration with the Montgomery County (Ohio) Office of Reentry. Participants completed a measure of self-efficacy for community reentry at pre- and post-session, followed by a brief interview to identify their plans for obtaining reentry services in the community. In support of Hypothesis 1, it was found that the self-efficacy for coping with community reentry improved from pre- to post-intervention. Consistent with Hypothesis 2, both residents with and residents without a disability benefited from the session at approximately equal levels. Post-session interviews revealed that a majority of residents expressed intentions to obtain additional reentry-related resources.

Keywords: recidivism, community reentry, homeless, disability, self-efficacy, participatory community action research in homeless shelters

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The purpose of this Honors Thesis is to examine the effects of a reentry-style session implemented within the setting of a homeless shelter to circumvent the barriers that exist in accessing community resources. In this study, the intervention attempts to enhance self-efficacy for community reentry. Overall, this document is organized into several sections: Introduction, Method, Results and Discussion, and Personal Reflection.

Introduction

The Introduction is organized into several subsections. The first subsection discusses the reciprocal relationship between homelessness and incarceration. This is necessary to show the importance of providing reentry support services in the actual homeless shelter environment. The second section discusses literature showing various barriers to accessing community resources, including barriers to reentry services. The third subsection summarizes disabilities in both the unhoused population and the incarcerated population. Given that the intervention in this study utilized attempts to improve self-efficacy for community reentry, the next subsection provides a brief review of Bandura's self-efficacy theory. The final subsection of this Introduction focuses on the present study, including the background or context for the study, the purpose of the study, and the hypotheses examined.

Reciprocal Relationship Between Homelessness and Incarceration

The topics of incarceration, homelessness, and recidivism are incredibly complex in modern times. These systems are highly connected and are among the growing problems in the United States. Research shows that the U.S. contains 5% of the total population, yet it houses 20% of the world's prison population (American Civil Liberties Union, 2022). The rate of

incarceration within the U.S. is between 5-10 times higher than in other Western democratic nations (National Research Council, 2014). The rates of recidivism among the previously incarcerated are incredibly high as well. While it is difficult to compare recidivism rates across countries due to conflicting definitions of recidivism, the U.S. numbers are extraordinarily high – it is estimated that 2/3 of the 600,000+ individuals who are incarcerated and released from prison each year will be rearrested within three years (U.S. Department of Justice, n.d).

Several difficulties in community reentry lead to these high recidivism rates. For instance, previous research shows that disabilities are particularly high in the incarcerated population, ranging from mental illness to drug addiction (Lorna, 2014). While social support can buffer the negative effects of disabilities and incarceration, studies find that those with a history of mental illness have poor social integration and fewer family ties (Bahr et al., 2005; Western et al., 2015). Individuals who were convicted of a crime and have disabilities often find it particularly difficult to find stable resources such as housing and jobs. Although having stable employment reduces the chance of recidivism, those who have been convicted are 50% less likely to get called back following an interview (Berg & Huebner, 2011; Pager, 2003). It is important to recognize that these factors do not exist in separate vacuums. Each factor is a risk factor for the other, as indicated by Snow and Reeb (2013). Therefore, a full understanding considers this multidimensional quality by taking into consideration all risk factors and their interactions. These difficulties in community reentry among all people who were previously incarcerated and barriers to accessing community resources are discussed in more detail in later subsections.

Homelessness is one of the most prominent difficulties following incarceration. The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act identified

four types of homelessness: those without homes, those who are about to be homeless, unattended individuals younger than 25 who don't meet the criteria for homelessness under this new system, and those in need of support while fleeing dangerous situations (U.S. Department of Housing and Urban Development, 2011; Housing and Urban Development Exchange, 2019). Previously incarcerated individuals can fall into any of these categories.

Studies continue to show a relationship between incarceration and homelessness. The rate of homelessness for individuals who were incarcerated is about 10 times higher than the general population and 15% of the incarcerated population has been homeless (Greenberg & Rosenheck, 2008). The risk of shelter use is at its highest immediately after release from incarceration; however, about 50% of individuals turn to homeless shelters two years after their release, suggesting a long-term relationship between reentry and homelessness (Remster, 2019). One study found that a little over 20% of homeless adults reported being incarcerated at least once in the previous two years (Metraux & Culhane, 2006). Predictably, a strong relationship between homelessness and recidivism exists as well. Homelessness is a strong predictor of recidivism in that it increases the risk of recidivism by about 50% (Jacobs & Gottlieb, 2020). Homelessness also increases the risk of incarceration and recidivism through indirect connections by aggravating the many reentry problems mentioned above. For example, unstable housing is linked to higher rates of hospitalization, a decreased ability to find jobs, and poor access to educational opportunities (Rollings et al., 2022; Reid et al., 2008; Marcal et al., 2023; Ferguson et al., 2012).

Many of these factors, including homelessness, can be targeted within the variety of reentry programs that are provided every year. While the components of these programs vary, the most successful ones have four key components. These are: starting the reentry program early in

release, using evidence-based approaches in treatment, assessing other reentry programs to learn from them, and altering misperceptions held about the previously incarcerated (Planstreet, 2020). *To our knowledge, little-to-no research has been done on the effects of reentry support sessions implemented within an actual homeless shelter setting.* However, numerous studies have examined the positive effects of other goal-directed programs. For example, Lutze et. al., (2014) found that the implication of a Reentry Housing Pilot Program significantly reduced new convictions for participants. Similarly, Nyamathi et al. (2017) showed that paroled men who stayed in a residential drug treatment program for at least 90 days or engaged in a substance abuse program agreement as part of a residential drug treatment program demonstrated a reduced likelihood of being rearrested. A program in Ohio provided individuals with a disability who had recently been released from incarceration with stable housing and found that it reduced several components of recidivism (Fontaine et al., 2012).

Barriers to Accessing Community Resources

To demonstrate the importance of providing a reentry-related intervention for residents in a homeless shelter with past incarceration, it is critical to take a closer look at the barriers that unhoused individuals face concerning utilizing community resources (including a community-based reentry program). The largest literature regarding barriers to community services involves healthcare because about 73% of unhoused individuals have at least one unmet healthcare need (Cernadas & Fernández, 2021; Baggett et al., 2010). Cernadas and Fernadez (2021; see also: Gillis & Singer, 1997; Torres Sanchez, 2021) describe three types of barriers to proper healthcare for those without housing. These include (a) barriers related to unhoused individuals (e.g., lack of trust in healthcare workers, lack of mobility/transportation, poor social support, economic impairment); (b) barriers due to the healthcare system at large (e.g., cost, lack of

flexibility/continuity/responsiveness, lack of insurance); and (c) barriers associated with healthcare professionals (e.g., stigmas/attitudes, discrimination)

These same barriers appear to apply to those with a history of incarceration. Salem et al. (2021) specified several of these barriers at an individual, program, and societal level. In their study, they examined individuals with a history of incarceration and homelessness who were taking part in residential drug treatment programs. At an individual level, the barriers included a lack of knowledge about resources (e.g., not knowing what resources exist, perceiving a lack of social support, belief in a lack of resources due to past experiences), and a lack of financial stability. At a program level, barriers included lack of technology access (e.g., internet, phones, emails), too long wait times while trying to receive employment, and lack of educational resources. Beyond program-level barriers, the researchers also identified societal barriers. These included a lack of healthcare access, issues in navigating larger systems (i.e. the court system), a lack of employment/minimum wage issues, and housing options. Therefore, it appears that having a history of incarceration also compounds some of the obstacles to accessing community resources to their fullest extent.

Social stigma is a significant barrier to reentry. Feingold (2021) identified three types of stigma associated with incarceration and how they have been studied in research. These three types of stigma include enacted (i.e. external experience of discrimination), perceived and anticipated (i.e. perceptions of how society views an individual and if they expect to be rejected as a result), and internalized stigma (i.e. applying the public's perception toward the self). Research indicates that enacted, perceived/expected, and internalized stigma have an impact on certain reentry processes (Salem et al., 2021; McWilliams & Hunter, 2020; Moore & Tangney, 2017; Newman & Crowell, 2023; Feingold, 2021).

Homelessness is also heavily stigmatized. For instance, Harris and Fisk (2006) found that when shown photos of unhoused individuals, participants' neuroimaging results were interpreted as indicating signs of disgust. Similarly, Bhui et al. (2006) found that the homeless are often on the receiving end of degrading treatment such as having been spit on and refused service. Other studies show that the general public is aware of, and sometimes exaggerates, several associations for unhoused individuals such as mental illness, substance abuse, and criminality (Snow & Reeb, 2013; Arumi et al., 2007; Link et al., 1995; Tompsett et al., 2006). These findings indicate that unhoused individuals with past incarceration face stigma associated with both groups.

As reviewed below, many unhoused individuals have some type of disability (or multiple disabilities). Disability has been defined as follows by the U.S. Government Social Security Administration (2013):

> "…inability to engage in any substantial gainful activity…by reason of any medically determinable physical or mental impairment(s)…expected to result in death or…has lasted or can be expected to last…no less than 12 months"

If an unhoused individual with past incarceration also has some type of disability (or multiple disabilities), then they may also face a type of discrimination referred to as ableism (see introduction to special journal issue on ableism by Bogart and Dunn, 2019). Campbell (2001) defined ableism as follows:

> Ableism refers to a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human. Disability then is cast as a diminished state of being human (p. 44).

Thus, ableism can be dehumanizing. It can also lead someone to draw erroneous conclusions about a person with a disability, such as assuming that a person with a disability is incompetent in some behavioral domain, when in fact the person may be perfectly competent in that domain. Such erroneous conclusions can lead to discrimination (e.g., making a decision not to hire a person with a disability even when the person has good qualifications for the job). Thus, an unhoused person with a disability and a history of incarceration may face a variety of types of social stigma, which can have an added negative effect, as illustrated in a recently published study by Snow-Hill et al. (in press; see also Snow & Reeb, 2013).

Summary of Disabilities in Unhoused and Incarcerated Populations

Depending upon the type of disability, some of the barriers delineated above are likely to become more pronounced for an unhoused individual. Consider the following examples: an unhoused person with a physical disability (accompanied by mobility problems) may find transportation to be an even greater challenge than usual, or an unhoused person with a mental disorder (and history of being victimized by social stigma) may experience fear or reluctance in reaching out to access community services. Given the additional complications caused by disabilities, it is critical to show that both physical and mental health disabilities are particularly common among unhoused and previously incarcerated persons.

Disabilities Among Unhoused Individuals

The research indicates that individuals without housing have large amounts of physical and mental health disabilities. Regarding physicality, physical disabilities are estimated at about 20% of the homeless population (Barile et al., 2018; Guillén et al., 2021). In addition, there are numerous health- and hygiene-related risks within shelters (Moffa et al., 2019). Compared to the general population, there is a higher rate of medical conditions and diseases such as joint issues,

respiratory infections, high blood pressure, walking difficulties (Weinreb et al., 2007), COVID-19 (Bagget & Gaita, 2021), diabetes (Asgary et al., 2022), HIV (Culhane et a., 2001), and cardiovascular disease (Jones et al., 2009).

Regarding mental disabilities, findings range from 20%-50% of this population dealing with severe mental illness (Roy et al., 2014). Weinreb et al. (2007) found excessive alcohol use at about 42% and illegal drug use between 25%-50% in this population. Suicidality rates are high (Coohey et al., 2015) and about 90% of this population show signs of at least one symptom of PTSD (as reviewed in Piening & Bassuk, 2007).

Disabilities Among Incarcerated Individuals

Unfortunately, rates of disabilities are also high within the incarcerated population. About 40% of all state prison populations nationwide are impacted by disabilities (Maruschak et al., 2016). The spread of infectious diseases, such as COVID-19, is high within this population with about 17% of people in prison having contracted an infectious disease at some point in their incarceration (Wang, 2022). Bai et al. (2015) found that the most prevalent health conditions among those incarcerated include respiratory problems, cardiovascular disease, and STDs. They also have higher rates of hypertension, arthritis, asthma, cervical cancer, and hepatitis as compared to the general population (Binswanger et al., 2009).

Mental health-related disabilities/disorders can be up to 15.8 times more prevalent among individuals in incarceration compared to the general population (Baranyi et al., 2019). Substance abuse disorder is found in about 43% of the population (Van Buitenen et al., 2020) and this chance increases if the incarcerated individual has PTSD (Facer-Irwin et al., 2019). Death by suicide in incarcerated men is 3-6 times higher than in the general population (Fazel et al., 2016)

and individuals within prisons who deal with mental health disorders are more often involved in violent incidents (Schenk & Fremouw, 2012).

To sum up, a wide variety of disabilities are disproportionally found among both unhoused individuals and incarcerated individuals. Thus, the likelihood that an unhoused individual with past incarceration has at least one disability is likely to be high.

Self-Efficacy Theory

The theoretical background for this study is based on self-efficacy theory. We implemented a reentry-style session within St. Vincent De Paul's Gateway Shelter for Men to increase self-efficacy for community reentry among shelter residents with past incarceration. Self-efficacy refers to the belief in one's capabilities. More specifically, it refers to "a conviction that one can successfully execute the behavior required to produce [intended] outcomes" (Bandura, 1977, p. 193). Concerning reentry, a high self-efficacy would mean that the individual truly believes they have what they need to successfully reenter society following a period of incarceration. Successful reentry refers to more than just being released from incarceration and successful reentry outcomes differ from program to program. In general, successful reentry refers to the reintegration of the complete individual into their community. This is based on a variety of measures such as job training to obtain employment (when applicable), housing access, educational opportunities, overcoming/managing psychological and substance abuse problems (when applicable), and more (National Conference of State Legislatures, 2023).

It is believed that higher self-efficacy translates to the completion of desired behaviors. As reviewed by Bandura (1977, 1982, 1995, 1997, 2016), decades of research support the hypothesis that: "expectations of personal efficacy determine whether coping behavior is initiated, how much effort will be expended, and how long it will be sustained in the face of

obstacles and aversive experiences…'' (1977, p. 191). Therefore, the goal is that if participants complete the session, not only will they believe they can successfully reenter society, but they will engage in the behaviors that are necessary to do so.

The Present Study

The Context of the Study

This Honors Thesis was conducted within the framework of a 12-year ongoing participatory community action research collaboration (i.e., the *Behavioral Activation Project in Homeless Shelters*) between Dr. Roger N. Reeb (Professor of Psychology at the University of Dayton) and administrators, staff, and residents at homeless shelters affiliated with St. Vincent de Paul (Dayton, Ohio). A comprehensive description of this Project is beyond the scope of this document, but a brief summary is warranted. This Project is transdisciplinary (Tress et al., 2006), guided by a systems perspective (Psycho-Ecological Systems Model; Reeb et al., 2017b), and utilizes participatory community action research (Strand et al., 2003) as well as service-learning pedagogy (Bringle et al., 2016) to implement behavioral activation (Kanter et al., 2010) in homeless shelters. Behavioral Activation is an evidence-based practice (Sturmey, 2009), which involves the provision of opportunities for personal growth, reinforcement, encouragement, and support (Kanter et al., 2010).

In this long-term (and ongoing) Project, behavioral activation serves as a general reinforcement-based framework for providing a wide range of opportunities for residents of shelters to engage in productive activities. Residents are encouraged and supported as they participate in these activities, which are meant to result in reinforcement (or sense of reward), a more meaningful shelter stay, improvements in psychological functioning, and improvements in abilities to overcome (or manage) problems – both personal challenges and systemic barriers. As

reviewed by Reeb et al. (2024), behavioral activation has been effective in treating (or managing) a multitude of problems encountered by individuals (adults and children), and it can be implemented in individual or group settings. Further, the use of behavioral activation is uncomplicated and inexpensive, and it requires less training to implement. This means that it can be implemented with success by non-psychologists and paraprofessionals (Jacobson et al., 1996; Martin & Oliver, 2018) and lay volunteers (Raue et al., 2022). While the approach has been used in a variety of settings, we know of no other documentation of it being used in a homeless shelter.

Sessions provided by this Project to shelter residents attempt to (a) increase self-sufficiency (e.g., computer training), (b) strengthen coping strategies (e.g., relaxation training), and (c) provide a positive shelter climate that facilitates rapport among residents, staff, and members of the behavioral activation team (including students). Approximately 1,500 shelter residents have participated in this Project over the years. Quantitative and qualitative research findings reported by Reeb et al. (2017, 2024) show that residents perceived behavioral activation sessions as meaningful, important, enjoyable, and worthy of repeating. In addition, this research shows that, during the shelter stay, residents view these behavioral activation sessions as contributing to hope, empowerment or self-sufficiency, quality of life, purpose in life, emotional well-being, social support, and positive shelter atmosphere and connection with staff (Reeb at al., 2017; Reeb et al., 2024). Residents with past incarceration have participated in (and benefited from) this Project over the years. However, this is the first time that, within the context of the general Project, an intervention has been implemented and examined that was specifically designed to enhance community reentry for residents with past incarceration.

This Project was viewed as a proper context for conducting the present study because the Project has served as an infrastructure for a variety of independent research projects by students (graduate and undergraduate). Most recently, for example, an M.A. Thesis (Clark et al., 2024) provided a health advocacy intervention to shelter residents and found that it enhanced their self-efficacy for self-care.

Purpose of the Study

The purpose of this Honors Thesis was to develop, implement, and evaluate the effects of a reentry-related intervention for shelter residents with past incarceration. The intervention focused on increasing self-efficacy for community reentry. Although residents with past incarceration have participated and benefited from the Project before, this is the first time that, within the context of the general Project, an intervention to enhance community reentry for shelter residents with past incarceration has been implemented and examined. A review of the published literature did not identify past studies examining a reentry-style intervention implemented within the actual homeless shelter setting. The goal is that, by implementing it within the shelter itself, residents can get around some of the barriers that unhoused individuals encounter when attempting to access community resources.

Hypotheses in the Study

Given the past research on the Behavioral Activation Project and self-efficacy theory, this Honors Thesis examined two apriori hypotheses.

- Hypothesis 1 was that reentry support sessions will enhance the self-efficacy for reentry coping behavior for shelter residents with past incarceration.
- Hypothesis 2 was that shelter residents with differences in disability status (e.g., those with no or one disability versus those with multiple disabilities) would participate in the

reentry session and benefit from the session (i.e., show pre- to post-intervention improvement in self-efficacy for community reentry). Given this hypothesis (i.e., the notion different disability groups would respond similarly to the intervention), it was believed that the interaction effect between disability groups (no or one disability versus multiple disabilities) and time (pre- versus post-intervention) would not be statistically significant.

Method

Participants

A total of 26 male participants engaged in the reentry support session offered at the shelter, but data analysis only involved 20 participants, because 6 participants left early and did not complete the session (or did not complete the assessment), did not agree for their data to be used in research, or were found to not have a history of incarceration. Consistent with the implementation of the Behavioral Activation Project over 12 years, no resident was denied services, including those who did not agree to have their data used for research purposes. Each participant was a resident at St. Vincent De Paul's Homeless Shelter (Dayton, Ohio) and had a history of incarceration. Race/ethnicity of the 20 participants included 6 white/Caucasian, 1 Hispanic/Latino, 9 Black/African American, and 4 other/prefer not to say. The ages of the participants fell between 32 and 68 years (M = 49.7, SD = 10.33). Further broken down, the ranges include: 32-37 (4); 38-43 (2); 44-48 (2); 49-53 (5); 54-58 (3); 59-63 (3); 64-68 (1). Disability status was also measured via self-reporting due to privacy guidelines within the shelter. The breakdown of disability status was as follows: 6 individuals with only physical disabilities; 4 with only mental disabilities; 4 individuals with physical disabilities, mental disabilities, and substance abuse; 1 person with both a physical and mental disability; 2 people

with both mental disabilities and substance abuse; 3 people with no disability status. With this breakdown in mind, a decision was made to compare the following two disability groups in this study: (a) residents with no disability or one disability (n = 13) and (b) residents with two or more disabilities (n = 7).

Measures

Brief Demographic Measure

After reading and completing the informed consent, the participants filled out a brief Demographic Measure. This measure included self-report of age, race/ethnicity, and disability. The IRB approval for the study included approval to request this information from shelter residents.

Reentry Coping Self-Efficacy Subscales

Ta (2016) developed and provided preliminary validation of a psychometric instrument assessing self-efficacy for coping with community reentry for those who are incarcerated or have past incarceration. The Offender Coping Self-Efficacy Scale (OCSS) has six subscales that can be broken into two categories based on location: incarcerated setting and reentry setting. Given the purpose of the present study, participants completed the Reentry Coping Self-Efficacy Subscales (see Appendix A). The reentry subscales consisted of (a) task and problem coping, (b) social support coping, and (c) emotion coping. It included 25 items on a Likert scale ranging from 1 (Strongly Disagree) to 7 (Strongly Agree). Ta (2016) created this scale and reported convergent validity with other measures of coping self-efficacy. The entire original scale was found to be internally consistent (α = .92). Ta (2016) also found that each reentry subscale that was used in this honors thesis was individually reliable (task and problem coping α = .80; social support coping α = .77; emotion coping α = .86). Within the present study, Cronbach's Alpha

was calculated for each subscale used pre-and post-intervention. The task and problem coping subscale was found to be reliable (pre $\alpha = .82$; post $\alpha = .93$), as was the social support coping subscale (pre $\alpha = .91$; post $\alpha = .92$), and emotion coping subscale (pre $\alpha = .93$; post $\alpha = .94$). In addition, the entire scale was found to be reliable in this study for both pre- ($\alpha = .96$) and post- ($\alpha = .97$) intervention.

Activity Evaluation Process Measure

The Activity Evaluation Process Measure (AEPM; see Appendix B; Reeb et al., 2024) is used as a "process check" (i.e., to make sure that shelter residents experience benefits from any given session before continuing to implement it). The AEPM includes 4 Likert-like items, with scores ranging from 1 (*not at all*) to 7 (*very much*), to assess if residents perceive the intervention as meaningful, important, worthy of repeating, and enjoyable and there is a section where participants can provide written comments. This scale is included in all studies completed within the Behavioral Activation Program to ensure that the interventions provided are meaningful for future guests. The AEPM has been found reliable ($\alpha = .88$; Glendening, 2015). Within the present study, Cronbach's Alpha was calculated as $\alpha = .96$.

Brief Interview Follow-Up

The participants were all asked to participate in a brief interview (see Appendix C) following the session. This interview was done to identify some of the more qualitative and detailed aspects of reentry and self-efficacy. They were first asked if they were now considering attending the Reentry Career Alliance Academy (RCAA) (Montgomery County, n.d). If they said yes, we offered them help in attending the program. If they said yes or no, they were asked what led them to this decision, with some possible prompts available if participants had trouble answering. The second question asked them if they had heard of the RCAA before this

intervention and, if so, where they had heard of it. The interviews were completed individually as opposed to in a group format. Rather than recording interviews, the researcher simply kept notes on each interview to ensure that answers to important questions could be obtained.

Procedure

The long-term Behavioral Activation Project received full IRB approval about 12 years ago, and it has been approved every year without difficulty. To conduct this study, IRB approval for minor revision in the overall study was obtained. After receiving approval from the IRB, various strategies were put in place at the shelter to encourage residents with past incarceration to attend. These strategies, which were approved as part of IRB approval, included word of mouth, posters, and announcements over the intercom. When participants agreed to attend, they were asked if they had a past incarceration and if they would be willing to contribute to the research efforts. If they did not fall into both of those categories, they were still allowed to attend the session, but their data was not included in the analysis. After 5-6 participants had been recruited, they completed the necessary forms, and then the standardized 30-minute-long session was implemented. The session covered the goals, expectations, benefits, and workshops offered by the Reentry Career Alliance Academy (RCAA) (Montgomery County, n.d). Table 1 provides a summary of the information offered to residents and the experiential activities that they participated in during the session.

The stand-alone session (summarized in Table 1) included a variety of information about the Reentry Career Alliance Academy (RCAA) in Montgomery County (Montgomery County, n.d). This program was created and is facilitated by the Montgomery County Office of Reentry. For about 3 weeks, I attended 2-3 classes a week that were offered in this program. I tried to ensure that the classes I attended allowed me to see the full breadth of classes (e.g., job

Table 1

Description of Community Reentry Shelter Intervention

To become prepared to provide the shelter reentry intervention, I sought an overall understanding of the Reentry Career Alliance Academy (RCAA) created by the Montgomery County Office of Reentry by attending 2-3 classes for 3 weeks. The RCAA provides 29 workshops from 9:00 am to 2:30 pm for 10 days. Attending workshops allowed me to provide residents with detailed information on day-to-day services. I developed a 20–30-minute session that included RCAA information (and information on how to access other community resources), with four sessions (each involving 5-to-6 residents) implemented over 4 weeks (summer 2023). I implemented each session, with the assistance of a graduate student. The session summarized the 20 RCAA workshops (organized into 4 categories) and provided concrete examples of workshop activities. The session was interactive, with questions and answers occurring throughout and at the end. Snacks/coffee were offered during the session, with information and support items provided at the end.

- Brief Overview: An overview of the RCAA was provided, including the overall goal (i.e., to make the reentry transition smooth by connecting participants with community resources), the holistic approach (i.e., focus on overall personal development, and not just job assistance), and the RCAA motto (i.e., Action, Alliance, and Accountability).
- Category 1 (Job Search): Names/types of workshops related to job searching were described. Participants were asked if they had experience in interviewing, what they felt after, and how they thought it could have gone better. In response to this, the "Mock Interviews" provided by the RCAA were discussed. In addition, the specific workshop entitled "Personal Branding" was explored as an example.
- Category 2 (Health and Bettering Yourself): Names/types of workshops related to health and bettering yourself were described. Participants were asked to generate their life habits and categorize them as "healthy" or "unhealthy." Then, one workshop ("Healthy Living") was explored as an example.
- Category 3 (Interpersonal Help): Names/types of workshops related to interpersonal health were described. The specific workshop entitled "Violence Prevention and Determined Identities" and an opportunity related to fatherhood identity ("Fatherhood Seminar") were explored as examples.
- Category 4 (Miscellaneous): Names/types of workshops not included in the above categories (e.g., education, spirituality, housing help) were described so residents could fully understand the holistic approach. Rather than providing a specific example, residents were encouraged to ask the presenter about details of any of these workshops.
- Benefits and Outcomes: The residents were shown what to expect upon completing RCAA, such as network building within the community; graduation ceremony; Career Passport Portfolio (including certificates, resumes, credentials, competencies/skills); proclamations (public statement of support); employment referrals; and move-in assistance once housing is available.

Table 1 (continued)

- What is the Commitment: RCAA time-related expectations (9:00 am to 2:30 pm for 10 days over 4 weeks), day-to-day activities, and related expectations were delineated.
- Working With You and Where You Are: The program was summarized again with an emphasis on how RCAA administrators are committed to working with participants regardless of their reentry stage.
- Additional resources: Additional reentry resources such as the app/website "Local Help Now" (https://montgomerycounty.localhelpnowapp.com/) were explored. This site provides links and phone numbers on a variety of resources such as food assistance, peer support, housing information, medication help, and more.

searching, health/safety, mental health, social support). The information provided in the thesis session consisted of the resources offered, examples of classes included in the program, and how we could help residents attend this program. Questions were always encouraged throughout the session, and this encouragement to ask questions was emphasized again at the end of the session. They were offered snacks/coffee during the presentation and then information and support items at the end. The Reentry Coping Self-Efficacy Subscales (Appendix A) were administered before and after the session. The brief interview (Appendix C) was employed following the session for those who were willing to be interviewed, and all participants agreed to do so. Subsequently, the participants were debriefed and thanked for their participation.

Results and Discussion

Effect of a Reentry Information Shelter Session on Self-Efficacy for Coping with Reentry

Hypothesis 1 was supported by a series of one-tailed paired-samples *t*-tests (See Table 2). That is, homeless shelter residents' scores on the Reentry Coping Self-Efficacy Subscales (Ta, 2016) improved between pre-intervention (M = 5.20, SD = 1.32) and post-intervention (M = 5.48, SD = 1.34), $t(19) = -2.83$, $r^2 = 0.30$, $p = .005$. This result was robust across the different subscales. For the "Task and Problem Coping" scale in a reentry setting, scores improved between pre-intervention (M = 5.44, SD = 1.16) to post-intervention (M = 5.69, SD = 1.34), $t(19) = -1.95$, $r^2 = 0.17$, $p = .033$. Scores also improved from pre-intervention (M = 4.86, SD = 1.61) to post-intervention (M = 5.21, SD = 1.45) on the "Social Support Coping" scale in a reentry setting, $t(19) = -2.28$, $r^2 = 0.21$, $p = .017$. Finally, scores improved from pre-intervention (M = 5.27, SD = 1.47) to post-intervention (M = 5.53, SD = 1.39) on the "Emotion Coping" scale in a reentry setting, $t(19) = -2.30$, $r^2 = 0.22$, $p = .016$.

Table 2

Means and Standard Deviations on the Reentry Coping Self-Efficacy Scales as a Function of Time (Pre- to Post-Intervention)

	Time of Assessment							
Reentry Coping Self-Efficacy Scale and Subscales	**Pre-Intervention**		**Post-Intervention**					
	M	***SD***	***M***	***SD***	***t***	***df***	***p***	***(r^2)***
Scale Total Scores	5.20	1.32	5.48	1.34	-2.83	19	.005	.30
Task and Problem Coping	5.44	1.16	5.69	1.34	-1.95	19	.033	.17
Social Support Coping	4.86	1.61	5.21	1.45	-2.28	19	.017	.21
Emotion Coping	5.27	1.47	5.53	1.39	-2.30	19	.016	.22

For several reasons, we believe that improvements in self-efficacy for coping with community reentry translated into improvements in actual reentry behaviors. First, approximately five decades of research on self-efficacy theory support Bandura's original hypothesis that "expectations of personal efficacy determine whether coping behavior is initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and aversive experiences…" (1977, p. 191). Second, the benefit and usefulness of the reentry session is highlighted by the results of the AEPM; that is, a set of one-sample *t*-tests, with four (middle value on the AEPM scale) employed as a conservative target, revealed that residents found the session to be beneficial in numerous ways (M = 5.34, SD = 1.95), $t(19)$ = 3.06, r^2 = 0.33, p = .003), including meaningful ((M = 5.30, SD = 2.03), $t(19)$ = 2.87, r^2 = 0.30, p = .005), important ((M = 5.75, SD = 1.94), $t(19)$ = 4.03, r^2 = 0.46, p = <.001), worthy of repeating ((M = 4.90, SD = 2.10), $t(19)$ = 1.92, r^2 = 0.16, p = .035), and enjoyable ((M = 5.40, SD = 2.16), $t(19)$ = 2.90, r^2 = 0.31, p = .005). Third, qualitative data from the brief post-session

interview (Table 3) illustrated an increase in knowledge and interest in reentry (and reentry services), with 16 of 20 participants asking more questions about Montgomery County's Reentry Career Alliance Academy and expressing interest in considering enrolling in it. Second, the effect sizes reported above (e.g., $r^2 = 0.30$) are considered to be large effect sizes (Cohen, 1988). Fourth, as shown in Table 4, there was pre- to post-session improvement on each of the Reentry Coping Self-Efficacy Subscales (Task and Problem Coping, Emotion Coping, Social Support Coping). In addition, preliminary analyses suggested that the pre- to post-session improvement was statistically significant in eight out of 25 items, with this pre- to post-session improvement closely approaching significance for four other items. Given the number of statistical analyses involved in examining pre- to post-intervention changes in subscales and individual scale items, these analyses must be viewed as preliminary or tentative in nature. Nevertheless, the analyses are important because (a) the specific results allow us to speculate regarding which areas of reentry self-efficacy tended to improve the most in response to the intervention; and (b) the specific results provide preliminary evidence of construct validity (Anastasi & Urbina, 1997; Cronbach & Meehl, 1955) for this relatively new psychometric instrument, especially because the validation study (Ta, 2016) did not examine changes in scores in response to interventions.

Even though there is reason to believe that the improvements in self-efficacy translated into actual reentry coping behavior, follow-up assessment (using psychometric instruments, systematic observations, and interviews) is necessary for future research to confirm the translation of improved self-efficacy for coping with reentry into improvements in reentry-related behavior over time. In future studies, we also recommend including a peer model (e.g., a current or past shelter resident with past incarceration who has shown some success in community reentry) because the inclusion of a model who has similarities to participants would

Table 3

Qualitative Information From the Interview

- What was it that helped you come to the decision to attend the reentry program?
    a. The large variety of workshops seems beneficial wholistically
    b. The need for specific help that is offered at the program (i.e. housing, money, substance recovery)
    c. It is an opportunity to get back on track
    d. The presenter providing the information seemed passionate
    e. They have known of the program before, but it seems like it has improved in what resources and help that is offered
- What brought you to the decision not to attend the reentry program?
    a. They already turned their life around but wish they had heard of the program before
    b. They have already attended in the past
    c. They are not sure if they are capable of doing the entire program but would like to reach out to the individuals who run it for advice/resources
- Have you heard of the reentry program in Montgomery County before? Where?
    a. The majority (11 participants) had not heard of it
    b. Of those who had heard of it:
        i. They had not heard of the one in this county
        ii. They had attended it before
        iii. They had heard about it at the shelter/from others
        iv. They had heard about it during their incarceration

likely enhance the influence of the intervention, and similar models with successful outcomes are particularly influential (Kazdin, 1976).

As mentioned previously, the pre- to post-session improvement on the subscale assessing self-efficacy for reentry was statistically significant in eight out of 25 items, with this pre- to post-session improvement closely approaching significance for four other items (Table 4). A brief discussion of these details is warranted for at least two reasons: (a) it may provide clues for how to improve upon (or extend) the community reentry-related session provided in the shelter for the future; and (b) given that there is only one study (i.e., a Dissertation) that provided preliminary validation of these subscales of reentry self-efficacy items, a consideration of which items changed (or did not change) in response to a pertinent intervention is relevant to establishing construct validity for a psychometric instrument (Anastasi & Urbina, 1997; Cronbach & Meehl, 1955).

As noted above, a preliminary (tentative) examination of which items changed in response to the intervention allows one to speculate about the specific effects of the intervention and also about how it could be improved. Scores on items about utilizing community/relationship resources and engaging in positive emotional problem-solving (i.e. using positive emotions to increase motivation in solving problems) tended to show a pre- to post-intervention increase (e.g., “I am confident in my ability to positively manage my emotions when faced with triggers”; “I am confident in my ability to look at the positive things I have going for myself”). This is likely because the intervention aimed to (a) show participants that a variety of beneficial and easily accessible community resources exist, (b) show participants how to access these community resources (and likely positive outcomes would result), and (c) create a positive mindset about community reentry coping behaviors and outcomes.

Table 4

Means and Standard Deviations on Reentry Coping Self-Efficacy Scale, Subscales, and Specific Items as a Function of Time (Pre- to Post-Intervention)

Reentry Self-Efficacy Item	Pre-intervention		Post-intervention		*t*	*df*	*p*
	M	*SD*	*M*	*SD*			
Average Across Subscales/Items	5.198	1.32	5.48	1.34	-2.83	19	.005*
Task and Problem Coping	5.44	1.16	5.69	1.34	-1.95	19	.033*
Item #1 - I am confident in my ability to get a stable job	4.30	2.45	5.45	2.14	-3.29	19	.002*
Item #2 - I am confident in my ability to find stable housing.	5.70	1.92	5.45	1.99	.815	19	.213
Item #3 - I am confident in my ability to identify situations that are triggering.	5.20	1.67	5.65	1.76	-1.25	19	.113
Item #4 - I am confident in my ability to avoid behaviors/ situations that got me into prison/jail.	6.35	1.18	6.10	1.21	.925	19	.183
Item #5 - I am confident in my ability to deal with conflicts that may arise with others in a way that maintains the relationships	5.10	2.02	5.80	1.44	-2.41	19	.013*
Item #6 - I am confident in my ability to ask others for information and resources with issues I need help with.	5.40	1.47	5.70	1.45	-1.37	19	.093*
Item #7 – I am confident in my ability to educate myself with current culture.	5.90	1.71	6.05	1.28	-.513	19	.307
Item #8 – I am confident in my ability to earn enough money to support myself.	5.80	1.64	5.50	2.01	.842	19	.205
Item #9 – I am confident in my ability to seek out medical/mental health care when I am ill.	5.20	1.85	5.50	1.70	-1.24	19	.115

Table 4 (continued)

Social Support Coping	4.86	1.61	5.21	1.45	-2.28	19	.017*
Item #10 – I am confident in my ability to contact my community supervising officer (probation officer) during times of distress.	5.15	1.93	5.15	1.66	.000	19	.500
Item #11 – I am confident in my ability to reintegrate into my family.	5.05	2.31	5.25	1.92	-5.15	19	.306
Item #12 – I am confident in my ability to reach out to others for support when I am upset.	4.45	2.11	4.75	2.05	-1.24	19	.115
Item #13 – I am confident in my ability to ask others to model appropriate behavior in the community.	4.85	2.08	5.25	1.74	-1.57	19	.067*
Item #14 - I am confident in my ability to seek out positive peer groups.	4.95	1.85	5.55	1.43	-3.04	19	.003*
Item #15 - I am confident in my ability to explain my criminal history to new people.	5.60	2.01	5.65	1.69	-.092	19	.464
Item #16 - I am confident in my ability to ask for financial help from family/friends during times of financial strain.	3.90	1.97	4.65	2.11	-2.38	19	.014*
Item #17 – I am confident in my ability to manage conflicts/disagreements that occur with authority figures	4.90	2.20	5.40	1.76	-1.75	19	.048*
Emotion Coping	5.27	1.47	5.53	1.39	-2.30	19	.016*
Item #18 - I am confident in my ability to positively manage my emotions when faced with triggers	4.95	2.06	5.50	1.57	-1.87	19	.039*

Table 4 (continued)

Item #19 - I am confident in my ability to manage how I feel if I am rejected based on my criminal history.	5.65	1.53	5.45	1.61	.607	19	.275
Item #20 - I am confident in my ability to walk away from conflicts	5.05	2.04	5.40	1.57	-1.51	19	.074*
Item #21 - I am confident in my ability to pick myself up when I am down in the dumps.	4.70	1.98	5.05	1.96	-1.23	19	.116
Item #22 - I am confident in my ability to look at the positive things I have going for myself.	5.40	1.76	5.65	1.66	-2.03	19	.028*
Item #23 - I am confident in my ability to focus on myself and not let other people's problems affect me	5.35	1.69	5.80	1.61	-2.27	19	.018*
Item #24 - I am confident in my ability to accept the consequences of my actions.	5.85	1.60	5.85	1.53	.000	19	.50
Item #25 - I am confident in my ability to bounce back from receiving difficult news.	5.20	1.70	5.55	1.57	-1.51	19	.07*

Notes. The * indicates that the change was statistically significant or approaching statistical significance in the expected direction. Given the number of statistical analyses involved in examining pre- to post-intervention changes in subscales and individual scale items, these analyses must be viewed as preliminary or tentative in nature. Nevertheless, the analyses are important because (a) the specific results allow us to speculate regarding which areas of reentry self-efficacy tended to improve the most in response to the intervention; and (b) the specific results provide preliminary validation of this relatively new psychometric instrument, especially because the validation study (Ta, 2016) did not examine changes in scores in response to interventions.

In contrast, scores on items that assess behaviors related to shelter living did not tend to show a pre- to post-intervention increase. There are certain items (e.g., “I am confident in my ability to find stable housing”) that residents are likely to experience significantly lower levels of confidence in even after the session, because they may not perceive having much control over such outcomes at this particular time. Similarly, items that assess more complicated problems, coping, or behavioral tendencies that may require counseling or psychotherapy to change (e.g., “I am confident in my ability to reintegrate into my family”; “I am confident in my ability to accept the consequences of my actions”) did not change in response to this 20–30-minute session that was mostly informational (and resource-oriented) in nature.

The findings suggest that providing reentry support within shelters may help circumvent some of the barriers in utilizing community resources as established by previous research (Salem et al., 2021; McWilliams & Hunter, 2020; Moore & Tangney, 2017; Newman & Crowell, 2023; Feingold, 2021); however, it would be good to expand upon the information discussed within this 20–30-minute reentry session. There are two recommendations for future studies in this regard. One possibility is to expand upon the session by making it longer which would allow for more in-depth discussion in general. A second option is to create a series of sessions that focus on individual topics over many days to allow for more in-depth discussion of specific topics.

With regards to the psychometric validity of the Offender Coping Self-Efficacy Scale (OCSS), this study replicated Ta’s (2016) in demonstrating high internal consistency for this scale. Ta (2016) also demonstrated several types of validity for the scale but did not examine the extent to which the scores on items of the scale improved in response to an intervention designed to facilitate community reentry. As noted above, a preliminary (tentative) demonstration that scores on specific items of a scale change in the expected direction in response to a relevant

intervention is relevant to one index of construct validity (Anastasi & Urbina, 1997; Cronbach & Meehl, 1955), and so this Honors Thesis extends the psychometric validity demonstrated for this scale by documenting the pre- to post-intervention scores.

Benefits of the Intervention for Different Disability Groups

Hypothesis 2 was also supported. To examine this hypothesis, an ANOVA (2 X 2) showed a nonsignificant interaction between the disability groups (one/none disability versus two or more disability) and time-of-measurement ($F(1, 18) = 1.369$, $p = .257$, $\eta^2 = .071$). The within-subjects main effect for time was statistically significant, $F(1, 18) = 9.457$, $p = .007$, $\eta^2 = .344$). However, the between-subjects main effect for the disabilities group was not statistically significant, $F(1, 18) = 2.296$, $p = .147$, $\eta^2 = .113$.

To establish the precise distinctions among these disability groups, additional t-tests were conducted in the follow-up analysis (see Table 5). The two or more disabilities group ($M = 4.53$, $SD = 0.87$) had lower scores than the one/none disabilities group ($M = 5.56$, $SD = 1.41$) at pre-intervention, $t(18) = 1.74$, $r^2 = 0.14$, $p = .05$ (one-tailed). The two or more disabilities group ($M = 4.98$, $SD = 0.99$) had lower scores than the one/none disabilities group ($M = 5.76$, $SD = 1.46$), $t(18) = 1.259$, $r^2 = .08$, $p = .112$ (one-tailed) at post-intervention as well. The Reentry Coping Self-Efficacy Subscales scores improved from pre- ($M = 5.56$, $SD = 1.41$) to post-intervention ($M = 5.76$, $SD = 1.46$) for the one/none disabilities group, $t(12) = -1.62$, $r^2 = .18$, $p = 0.07$ (one-tailed). The Reentry Coping Self-Efficacy Subscales scores also improved from pre- ($M = 4.53$, $SD = .87$) to post-intervention ($M = 4.98$, $SD = .99$) for the two or more disabilities group, $t(6) = -2.62$, $r^2 = .53$, $p = 0.02$ (one-tailed).

Table 5

Means and standard deviations on the Reentry Coping Self-Efficacy Scale as a function of time (pre- to post-intervention) and disability status

	Time of Assessment							
Disability Status	**Pre-Intervention**		**Post-Intervention**					
	M	***SD***	***M***	***SD***	***t***	***df***	***p***	***(r^2)***
No or one disability	5.56	1.41	5.76	1.46	-1.62	*12*	.07	.18
Two or more disabilities	4.53	0.87	4.98	0.99	-2.62	6	.02	.53

The findings of this study suggest that providing a reentry-style session within the homeless shelter setting may circumvent barriers to reentry for individuals who are homeless and have a disability. There are two important reasons for showing that shelter residents with and without disabilities had similar improvements in reentry self-efficacy. First, disabilities among the incarcerated population are high (Maruschak et al., 2016) which likely inhibits proper reentry into society. Second, stigmatization and discrimination are associated with disabilities and lack of housing (Hinshaw & Stier, 2008). There are a variety of recommendations for reentry sessions and future research that come from these findings. For one, as suggested by Clark et al. (2024), modeling by peers for those with general and/or specific disabilities and incarceration history could be implemented. In addition, a future study with a larger sample size (perhaps across different shelters) could help in determining the benefit of the intervention for residents with different types of disabilities, and this could also allow us to know how to best tailor the intervention for individuals based on disability status. For instance, future studies could examine the effect of reentry sessions on people with specific disabilities that are more associated with the incarcerated population such as arthritis, hypertension, substance abuse, and more (Binswanger et al., 2009; Van Buitenen et al., 2020).

Honors Thesis Student's Reflection on Experiential Education and Research

While working on this study I have learned a lot about what someone can do to make a difference. For instance, going into the Behavioral Activation Project and my own honors thesis, I had doubts about the true usefulness of behavioral activation when implemented by undergraduate students and about my own self-efficacy in providing this intervention. While I understood the research and felt trained professionals could engage in these activities, I was a little more doubtful about my abilities as an undergraduate student. I was not fully convinced of the possibilities until one of the residents at the shelter approached me about my reentry session and how he wanted to move forward in his reentry progress. It was at this moment that I realized anybody can make a difference in the community if they want to.

Everybody holds some level of bias about certain individuals, including the homeless and/or incarcerated population. Many of these biases are subconscious and are hard to change unless you expose them. During my time at the shelter, I have exposed several of my previous biases. This, ultimately, has aided in my ability to connect with and help the residents. For example, there was one specific night at the shelter when a young man came up to us. I assumed he was working at the shelter or visiting someone because he was about our age. But he was looking for some help in finding something because he was new at the shelter. He later went on to explain that he was a resident at the shelter but that he was going to college to get his degree. He was talkative and enjoyed telling us about his plans and his upbringing. I was astonished to learn that not only was this man on the same path as me, but he had a similar background as mine. Reflecting on this, I recognize now that people who are homeless or incarcerated can come from a multitude of backgrounds. Sometimes certain things in life make it easier to stay away from certain paths – i.e. specific privileges that are available to some, such as financial status,

proper social support, and safe environments. But it is always possible to end up in a place you never expected.

I intend to take away three lessons from my experience with this thesis: (1) you can never assume you know everything about a person based on where they are in life, whether that be in a shelter, a state of incarceration, or anything else; (2) the barriers that stand in the way of improving a situation are much more complicated than most people realize, and many of them are systemic in nature, such as transportation problems, disabilities, lack of technology, stigmatization, and so on, as opposed to being person-related; and (3) just because someone has ended up in a tough situation, that doesn't mean they don't deserve help in getting out and improving their lives. Overall, this Project has enhanced my self-efficacy and self-reflection which will help me make a difference in the lives of people in my community. The Project has given me confidence and knowledge in working with clients from various backgrounds as I will be doing as a case manager this year, as well as in the future when I pursue a doctoral degree in clinical psychology.

Summary

Within the context of the ongoing *Behavioral Activation Project in Homeless Shelters*, this study developed, implemented, and evaluated a brief intervention for homeless shelter residents with past incarceration. By implementing it within the shelter environment, we attempted to overcome barriers that unhoused residents face with regard to accessing community resources. The study found that residents who participated in the intervention showed a pre-to post-intervention improvement in self-efficacy for coping with reentry, and residents with differences in disability status benefited from the intervention in similar ways. Limitations of the study and recommendations for future research were presented.

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Appendix A

Reentry Coping Self-Efficacy Subscales

1. I am confident in my ability to get a stable job.

1	2	3	4	5	6	7
Strongly Disagree			Neither disagree/agree			Strongly agree

2. I am confident in my ability to find stable housing.

1	2	3	4	5	6	7
Strongly Disagree			Neither disagree/agree			Strongly agree

3. I am confident in my ability to identify situations that are triggering.

1	2	3	4	5	6	7
Strongly Disagree			Neither disagree/agree			Strongly agree

4. I am confident in my ability to avoid behaviors/situations that got me into prison/jail.

1	2	3	4	5	6	7
Strongly Disagree			Neither disagree/agree			Strongly agree

5. I am confident in my ability to deal with conflicts that may arise with others in a way that maintains the relationships.

1	2	3	4	5	6	7
Strongly Disagree			Neither disagree/agree			Strongly agree

6. I am confident in my ability to ask others for information and resources with issues I need help with.

1	2	3	4	5	6	7
Strongly Disagree			Neither disagree/agree			Strongly agree

7. I am confident in my ability to educate myself with current culture.

1	2	3	4	5	6	7
Strongly Disagree			Neither disagree/agree			Strongly agree

8. I am confident in my ability to earn enough money to support myself.

1	2	3	4	5	6	7
Strongly Disagree			Neither disagree/agree			Strongly agree

9. I am confident in my ability to seek out medical/mental health care when I am ill.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

10. I am confident in my ability to contact my community supervising officer (probation officer) during times of distress.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

11. I am confident in my ability to reintegrate into my family.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

12. I am confident in my ability to reach out to others for support when I am upset.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

13. I am confident in my ability to ask others (e.g., friends, family, co-workers, pastor, sponsor, etc.) to model appropriate behavior in the community.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

14. I am confident in my ability to seek out positive peer groups.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

15. I am confident in my ability to explain my criminal history to new people.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

16. I am confident in my ability to ask for financial help from family/friends during times of financial strain.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

17. I am confident in my ability to manage conflicts/disagreements that occur with authority figures.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

18. I am confident in my ability to positively manage my emotions when faced with triggers.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

19. I am confident in my ability to manage how I feel if I am rejected based on my criminal history.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

20. I am confident in my ability to walk away from conflicts.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

21. I am confident in my ability to pick myself up when I am down in the dumps.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

22. I am confident in my ability to look at the positive things I have going for myself.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

23. I am confident in my ability to focus on myself and not let other people's problems affect me.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

24. I am confident in my ability to accept the consequences of my actions.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

25. I am confident in my ability to bounce back from receiving difficult news.

1 2 3 4 5 6 7
Strongly Disagree Neither disagree/agree Strongly agree

Appendix B

Activity Evaluation Process Measure

Please circle the number that best answers the questions about the activity you just completed.

A. How much did you enjoy this activity?

1	2	3	4	5	6	7
Not at all enjoyable			It was okay			Very

B. How meaningful was this activity to you?

1	2	3	4	5	6	7
Not at all meaningful			It was okay			Very

C. How much would you like to do this activity again?

1	2	3	4	5	6	7
Not at all again			Maybe			Definitely

D. I believe that the activities of this study are important for guests at this shelter.

1	2	3	4	5	6	7
Not at all			Maybe			Definitely

Comments:

_____

_____

_____

Appendix C

Brief Interview Prompts

1) After attending the reentry's support and informational session today, are you considering attending the Reentry program?

a. [If interviewee says **YES**] That is great! I will get you set up with some resources so that we can make the process as smooth as possible. What was it that helped you come to this decision?

I. [If probing is needed]

1. The reentry information session that was just run
2. Prior resources that were provided to you
3. Encouragement from outside network like family, friends, parole officer, etc.

b. [If interviewee says **NO**] Okay! What are some of the reasons that brought you to this decision?

I. [If probing is needed]
   1. Transportation problems
   2. Time commitment difficulties
   3. The resources aren't applicable to you
   4. Concerns about the commitment period

II. [Follow up to **NO**] Is there something you can think of that would make the Reentry program more beneficial to you?

2) Prior to this session, had you heard of the Reentry program? a. [If interviewee says **YES**] Where did you hear it from?